REPORT RESUMES

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THE SAN ANTONIO REHABILITATION-WELFARE REPORT ON RESEARCH AND DEMONSTRATION PROJECT RD 1513.

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THE PURPOSE OF THE PROJECT WAS TO HELP PUBLIC ASSISTANCE RECIPIENTS EARN THEIR OWN LIVING THROUGH A JOINT EFFORT BY VOCATIONAL REHABILITATION AND PUBLIC WELFARE SERVICES. SPECIFIC OBJECTIVES INCLUDED (1) ESTABLISH METHODS OF IDENTIFYING POTENTIAL CANDIDATES, (2) DEVELOP AN INTERAGENCY OPERATING PATTERN, AND (3) DEVELOP AN ADEQUATE MEDICAL-PSYCHOLOGICAL-SOCIAL-VOCATIONAL REHABILITATION EVALUATION OF RECIPIENTS. THE PROJECT SAMPLE OF 113 WAS FROM THE TARGET POPULATION OF 3,200 FAMILY HEADS WHO WERE CHARACTERIZED AS HAVING LOW INCOMES, HIGH BIRTH RATES, LOW EDUCATION, AND PREDOMINANTLY LATIN AMERICAN GROUP MEMBERSHIP. A COOPERATIVE PLAN OF DUAL AGENCY FUNCTIONAL ACTIVITIES UTILIZED A COUNSELOR-CASEWORKER TEAM APPROACH, INTENSIVE CASE SERVICE, PREVOCATIONAL EVALUATION-ADJUSTMENT SERVICES, AND A COMPREHENSIVE CLIENT-FAMILY RESEARCH EVALUATION AND RATING SYSTEM. THE SEPARATE AGENCIES WERE ABLE TO WORK TOGETHER EFFECTIVELY. OF 181 CASES CLOSED, 38 PERCENT ENDED IN SUCCESSFUL EMPLOYMENT WHICH COMPARES WELL WITH A 2 PERCENT NATIONAL RATE. AN ADEQUATE REFERRAL SYSTEM WAS ESTABLISHED. WITH THE USE OF SPECIALLY DEVELOPED RESEARCH INSTRUMENTS, THE PREDICTION OF SUCCESS OR FAILURE IN REHABILITATION WAS MADE WITH CONSIDERABLE CONFIDENCE. INDIVIDUAL CLIENT SUCCESS (INCREASES IN WEEKLY EARNINGS) DEPENDED QUITE STRONGLY ON A PREVIOUSLY STEADY WORK HISTORY, EXTENSIVE VOCATIONAL TRAINING, AND ADEQUATE INTELLECTUAL FUNCTIONING. ON THE BASIS OF EXPERIENCE FROM THIS PROJECT, THE AGENCIES HAVE ENTERED INTO AN AGREEMENT TO COOPERATE ON PROJECTS ON A STATEWIDE BASIS. (JM)

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by

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THE SAN ANTONIO REHABILITATION-WELFARE REPORT

RESEARCH AND DEMONSTRATION

PROJECT RD 1513

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HIGHLIGHTS

The San Antonio Research and Demonstration Project, RD 1513, was implemented in February, 1964, in recognition of the special need for better rehabilitation services to disabled family heads receiving aid for dependent children (AFDC). The magnitude of need was indicated by the fact that AFDC family members totaled some seventeen thousand of San Antonio's seven hundred thousand metropolitan population, or about one in forty-one. The target population can be briefly described as inhabitants of a generally low-income section of the city where 1960 census indicated a $2881 annual salary as representative; birth rate as forty-four in contrast to twenty-five per thousand for the United States; and where about five years schooling was representative for those over twenty-five years. Review of records in 1965 indicated Project clientele to be ninety percent Latin Americans, seven percent Negro, and three percent Anglo. One client in every five had a police record; the average number of dependents was 5.17; claimed education was about sixth grade; and average client age was 38.6 years. The knowledge that increasing technological requirements for jobs and an in-rank population explosion are contributing to an ever-widening opportunity gap makes help for these disadvantaged people very urgent.

Essentially the Project goal was to demonstrate and to do research on ways to eliminate or reduce vocational handicaps and dependency characteristics to the point where AFDC recipients could become gainfully employed and participate more effectively as community members. With a VRA grant to help accomplish this goal, a plan was developed whereby the full resources and efforts of the Texas Department of Public Welfare and the Texas Education Agency, Division of Vocational Rehabilitation, were focused on the client and family. The full spectrum of normal services and those available from other community sources were offered with certain significant supplementary features. The latter consisted mainly of an in-house counselor-caseworker team approach, a special prevocational evaluation-adjustment facility, and intensive case work. Project design, methodologies, and efforts for the report period February, 1964, through June, 1966, are reported in detail to show what was planned, how it actually worked, the results, and recommendations.

Demonstration results show that thirty-eight percent of the total one hundred eighty-one closures, including those closed in referral status, ended in successful employment and that all cooperative clients benefited to some extent by Project services. Since this rate is significantly more favorable than the recognized national rehabilitation rate of two percent, one can be cautiously optimistic that some set of design features can be identified as the contributing cause for a higher success rate. The purpose of the research phase of the Project is to help answer questions of this nature including what human factors are indicative of rehabilitation success or failure. Routine assessment was made of some fifty human variables and two hundred fifty items of a Work Attitude Scale for each client. An outside research consultant used a computer and appropriate evaluation research techniques to isolate, insofar as possible, the specific factors that could have been used to predict rehabilitation success for clients during this demonstration period.

Results from research indicate that significant predictive factors are identifiable. Several prediction models have been set out; the most basic of which includes such factors as numerical aptitude, verbal aptitude, general aptitude, projectively assessed adjustment and rating of family affection. In subsequent clinical usage of a larger model, it is anticipated that appropriate failure prediction techniques will help identify areas of client weakness for intense remedial action. In this way, better services can be offered to help clients achieve rehabilitation success in greater numbers. Cross-validation is recommended.

On the basis of results, the two Agencies have entered a cooperative agreement to expand similar services over most of Texas with regular program funds. In addition, the Federal research grant has been extended at the San Antonio Project for the purpose of continued research and development of the prevocational evaluation-adjustment phase of activity.

PREFACE

In a world characterized by continuous change in all disciplines, there is little likelihood that social sciences will keep abreast of times without continuous demonstration and research efforts. The technological explosion in the physical sciences has outstripped expectations, while applied human sciences have lagged seriously. This lag is apparent in many aspects of life -- the social impact of new tools, devices and leisure, on one hand, and the threat to many disadvantaged and disabled peoples by an ever-widening opportunity gap caused by a runaway affluent society.

This Project is dedicated toward helping to close the opportunity gap by demonstrating more effective methods, techniques and procedures for working with disadvantaged and disabled people, and by doing research toward more effective assistance in rehabilitation services. Whatever progress the Project may achieve is dedicated in turn to the many people who have participated effectively in the activity, including clients who have exerted extremely beneficial influence on their peers.

Acknowledgement is well deserved by many, yet available space precludes mention of all but the most responsible and active participants. In addition to those listed as contributors, these include Mr. C.G. Fairchild, Assistant Commissioner for Vocational Rehabilitation; Mr. L.C. Rouse, Jr., Director of the State Department of Public Welfare; the late Thurman Covey of the State Department of Public Welfare; Mr. Doyle Wheeler, Director, Division of Vocational Rehabilitation (DVR); Miss Margaret Gregg, Director of Public Assistance, (SDPW); Mr. L.T. Johnston, Assistant Director, DVR; Mr. Raymond G. Cheves, Regional Director, SDPW; Mr. E.H. Stendebach, Area Supervisor, DVR; Mr. Joel E. Falcon, Assistant Regional Director, SDPW; Mr. Tom Deliganis, Supervisor, DVR; Mrs. Tessa F. Howard, original Project Supervisor, SDPW; Mrs. Silvia V. Morris, caseworker, SDPW; and Mr. Antony Svatek, past caseworker and now supervisor, SDPW. Current Project staff members include Director, Clyde C. McWhorter, DVR; Associate Director, Antoinette Lamonte, SDPW; Vocational Rehabilitation counselors, Mrs. Norma Franks, Mr. H.L. McLerran, Mr. S.R. Campisano; Department of Public Welfare caseworkers, Miss Dorothy Herms, Mr. Jack Norville, Mrs. Katrina Wood, Mr. Daniel Delgado; Mr. Henry Morales, prevocational instructor; Dr. Charles Schauer, medical consultant and John Pierce-Jones, Ph.D. Research Consultant; Robert Rast, Ph.D., Psychological Consultant, and a dedicated Project clerical staff. Contributing agencies and organizations include the San Antonio Public Housing Authority; Action for Community Development, Inc.; Mental Health Association of Bexar County; and Personnel Services Center, University of Texas. The contributions of these people and organizations have made progress possible in this cooperative effort.

Clyde C. McWhorter

Clyde C. McWhorter
Project Director

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CHAPTER I

PRELUDE TO ACTION

SECTION 1

INTRODUCTION AND PURPOSE

The inspiration and basis for action on the part of the parent agencies has been in their philosophy and commitment to rehabilitation as a process for strengthening our democratic society. It has been a matter of mutual concern that the Welfare category known as recipients of Aid to Families with Dependent Children (AFDC) have a characteristically significant complexity of environmental and personal handicaps to effective living and vocational pursuits.

PURPOSE

The original purpose of this research demonstration project was to increase the number of disabled recipients of, and applicants for, public assistance grants who are able to earn their own living as a result of vocational rehabilitation services provided by the Texas Education Agency's Division of Vocational Rehabilitation, and associated services to be provided by the Texas Department of Public Welfare as well as other cooperating agencies. It was expected that this project would apply and extend the knowledge, skills, methods, and techniques previously developed by research, demonstration, and service projects in the field of vocational rehabilitation.

SECTION 2

OBJECTIVES

The central objective set forth for the project was to demonstrate what might result with intensive and, if necessary, long-time work with families receiving an Aid for Families with Dependent Children grant wherein incapacity is a factor. The specific project objectives indentified in the original plan were:

1. Establish a systematic method of identifying those public assistance applicants and/or recipients who are potential candidates for vocational rehabilitation;
2. Develop, maintain, and continue an effective inter-agency operating pattern for the correlation of agency services for the optimum vocational rehabilitation opportunities and the well-being of disabled public welfare clients;
3. Develop fully an adequate medical-psychological-social-vocational rehabilitation evaluation of these individuals;

4. Provide, promptly, sufficient high quality rehabilitation services to these needy eligible persons through a coordinated plan of service, building toward optimum adjustment according to the individual and family needs and potentials;

5. Compile and analyze data pertaining to the clients served through this project, as they relate to costs and results;

6. Appraise the usefulness, strengths, problems and contributions of the project methods and techniques;

7. Provide promptly intensive care with each family in order to insure sufficient high quality of rehabilitation efforts;

8. Build toward the optimum adjustment in intra-family relationships and quality of child care;

9. Have a research aspect of the project, to measure and evaluate not only results but causes for failures and then more appropriate methods of approach;

10. Determine ethnic characteristics of the Latin-American clients that may deter or accelerate possibilities of vocational rehabilitation.

SECTION 3

JUSTIFICATION AND SCOPE

Our nation is in the throes of the greatest change and growth in its history; and yet somehow, one person in twenty-five is being left at the starting in the race toward an increasingly affluent society. Some eight million people are part of a swelling tide in need of welfare assistance; and among these, some of the most disadvantaged and resigned are the multi-handicapped AFDC recipients of our nation.

The administrative heads and respective staffs of the State Department of Public Welfare and the Texas Education Agency, Division of Vocational Rehabilitation recognized the need and set out to study the problem in Texas. For years the number of first and second generation of families on welfare had drawn the concern of social workers, sociologists, economists and legislators. A number of cooperative projects over the nation had been implemented; and, on the basis of available knowledge, experience and local need, the San Antonio area came under scrutiny.

The AFDC population in San Antonio is the largest in the State of Texas, numbering over 3200 family heads, of which twenty-five percent are disabled males and seventy-five percent females with a high disability incidence. This represents a sizable family population just short of 17,000 in this city of nearly 700,000 population. On the basis of such facts and the dream of L. T. Johnston of Rehabilitation and Thurman Covey of Welfare, Robert B. Beck implemented the San Antonio cooperative Project in 1964 with the aid of Vocational Rehabilitation Administration Grant RD 1513. A preliminary study of the project sampling in 1965 showed the clientele to be ninety percent Latin American, seven percent Negro, and three percent Anglo. This contrasts with the overall population which included only a slight majority for people of Latin American extraction over those of Anglo-German extraction. The Negro population of the city was about fifteen percent. One project client in every five had a police record, average number of dependents was 5.17, average claimed education was near sixth grade, and the average age was 38.6 years. Some had been childhood members of a welfare family. A sizable number of the sampling were of the type known as "hard core" cases; because in addition to various vocational handicaps, this type never had acquired (or had lost) the will to work toward independence. Many had multiple disabilities of some degree and a complexity of vocational handicaps.

The environmental center for most of the AFDC dependent population is San Antonio's west side, a region settled largely by Latin Americans. The vocational instability of the environment can be judged by the estimate that some fifteen thousand families are migratory workers. A like number is said to be technically unemployed, earning less than one thousand dollars per year. A representative annual salary according to 1960 census in west side high birth rate areas was $2881. One census tract showed a median annual salary of $1720; median number of years schooling, four, for those over twenty-five; and a birth rate comparable to Asia at thirty-six live births per thousand population. The birth rate averages forty-four per thousand population with one census tract showing a rate of sixty-eight per thousand. In contrast, the birth rate for the United States is twenty-five. Median years of schooling for persons over twenty-five living in west side high birth rate areas are about five years. Public housing is advantageous for many of these people; but, privately owned rent houses in pockets on the west, south, and east sides seldom rent for more than thirty dollars per month. Because of the overall large number of disadvantaged people willing to work and live day by day, San Antonio is characterized as having a cheap labor market. In spite of cheap labor, San Antonio has a disproportionately smaller amount of industry than the total population might seem to indicate. The economic strength is mainly from military and civil service payrolls from the many military installations clustered around the city. The historical and quaint features, such as the Alamo, the Venice-like water way, the Spanish Governor's Palace, the cathedrals, and other sights, make the city a heavy year-round tourist attraction even before the advent of HemisFair, 1968. Employment roles show sixty-three thousand on the federal payroll, sixty one thousand in trade, twenty-nine thousand in services, twenty-six thousand in manufacturing, and thirteen thousand in construction. Over the past years, sophistication of the local industry and advanced practices at military installations have raised the work qualification standards significantly. The opportunity gap has widened between the low wage earner and the middle-to-higher level wage earner. Thus, low wage earners and, even more so, the disabled AFDC recipient population find the technological explosion pushing mediocre jobs out ofreach while a population explosion in the ranks continues to increase the hazards of family deprivation and frustration.

The full resources and efforts of the two prime agencies along with other available community resources were focused on this target population. The advantages of specialization on matters relating to family and breadwinner was heightened by a workable plan of service and research, During the report period, a composite staff of two DPW caseworkers, DPW Supervisor, two VR counselors with one doubling as Project Director, and clerical workers, were jointly housed in a Federal Housing Project and carried out the plan. Many others assisted helping to make the Project an effective force in the community.

CHAPTER II

DEMONSTRATION

SECTION 4

RATIONALE

Three assumptions were initially identified as a bsis for Project functions. The first of these was the premise that the geo-eco-sociological environment had the necessary opportunities for the given population of dependent people to become independent. Interpretation of this assumption implied that professional techniques were necessary to facilitate use of environmental opportunities. In application, the following question was posed: "What is the project personnel's responsibility to disadvantaged people with regard to job placement?"

If one assumed that the goal of rehabilitation programs was functional independency for clientele served, then the primary responsibility for such activity should basically be engendered in and remain with the client and his family. Logically, it would follow that the primary role of project personnel was to guide and offer new opportunities to individuals who had not been able to resolve their problems by themselves; and then utilize counseling and intensive casework to help them perceive these opportunities as such. On this basis, the operational assumption was that project personnel would work actively toward improving living standards, search for new job opportunities, and endeavor to upgrade the disabled person's skills and functional levels.

The second basic assumption was that the acquisition and nature of information about clientele and their circumstances should be reasonably adequate, reliable, and valid. Relative to this assumption was the question, "What evaluation criteria will be used to gather the information?"

Prior to proof of reliability and validity, some arbitrary selection of evaluational criteria was made on the basis of available reports and experience, as set out in Appendix "A". It was expected that application of appropriate research methods and techniques might result in identifying causative factors relative to existing circumstances. Depending on the nature of specific factors, the relationship could be either an asset or a liability. In this project the observed circumstances happen to be a state of client dependency; therefore, it was expected that many factors contributed to the debilitating condition. In general, it would be considered unusual for only one factor or problem to cause a state of dependency. For example, one man with a heart condition might be dependent on public assistance, yet many others with heart conditions remain independent. In a given case it most likely includes some combination of personal, social, educational, physical, mental, economic, geographical, and other circumstances.

The probability that most circumstances result from a complexity of variables makes it desirable to identify as many of these variables as possible. Since research might result in the capability for predicting either failure or success, the evaluation process should identify assets as well as liabilities. Also, such an evaluation system was assumed to be a valid basis for reaching the functional goal in which the clientele is helped to manipulate or alter factors to their advantage.

Another consideration in the reliability and validity of information descriptive of the clientele is that assessment is based largely on judgment. Since the investigation of human behavior is based characteristically on judgments with the connotation that it produces second rate information, some thought and preparation was directed toward maximum objectivity in discrimination. For example, it was anticipated that a medical doctor would review the medical evidence and make professional research ratings for a client's physical status; that social caseworkers would assess family conditions and make similar professional research ratings; and that rehabilitation counselors would assess those conditions and attributes of the client having relevance for his productivity level and potential. In addition, the development of discrimination scales (Appendix "A") was expected to strengthen the assumption that valid judgments can be made in areas of specilization by professional people.

The third basic assumption was that the services rendered by the participating agencies are identifiable and complementary. Implied in the assumption are the following questions: What will be the primary responsibilities of DVR personnel and likewise, the responsibilities of DPW personnel? What approach needs to be employed in order to integrate the activities of these two agencies? The approach chosen included identification of the goals for the respective agency personnel.

What are the functional goals for these two agencies? Policies of both agencies express a desire to enhance, improve, and offer significant services to their clienteles. For DPW, the concern for helping people so as to remove reasons for dependency is as great as that evidenced in the DVR program. Therefore, the specific goals of the different personnel units would not be identified if one were simply to say that the joint goal of the two agencies is to remove those factors which cause dependency, even though it is understood that this is the major goal of demonstration programming for the project.

By taking two expressed purposes of the participating agencies, (1) aid to families of dependent children and (2) rehabilitation of disabled individuals, and by manipulating to some extent pertinent concepts, goals were evolved for the respective members of the project team. The assumption was maintained that responsibilities of DVR personnel are primarily to the individual client while responsibilities of DPW personnel are primarily to that individual's family. Therefore, the goal for rehabilitation activities relative to the client is to offer opportunities he needs to become productive. As its counterpart, the goal for services to the family is to offer opportunities so that adequate functional levels of living for the family can be achieved. In table I responsibilities for the respective personnel units are identified.

Finally, two points were considered necessary to facilitate and maintain effective communication between team members. First, the inter-personal relations between team members should be such as to allow freedom of thought. (Good inter-personnel relations were recognized as being so important that, if effective work is to be done, each team member must actually feel that he is equal and is as important to the project as any other member, but that he needs the help and assistance from them as they need his.) Secondly, a system of day-to-day communication pertaining to identification of problems, and services should be such that each team worker can keep track of what services are being offered to whom and when they are offered by other staff members.

Table I

RESPECTIVE TEAM MEMBERS' GOALS

Primary Project Responsibilities

DVR Personnel	DPW Personnel
TO THE INDIVIDUAL (Goal - Productivity)	TO THE FAMILY (Goal - Adequate Living Standards)
Primary Responsibilities	Primary Responsibilities
1. Identification of individual's problems.	1. Identification of familial problems.
2. Identification of individual's desires and abilities.	2. Identification of family's desires and potentials.
3. Services rendered to take advantage of assets and limit liabilities to upgrade the individual's functioning.	3. Services rendered to take advantage of assets and limit liabilities to upgrade the functioning of the family.

SECTION 5

DESIGN FOR RESEARCH

Prior to the actual formulation of the research design, attention was given to identification of a philosophy or theoretical base from which the design might evolve. The basic issue on which this endeavor focused was: does one design so the results of demonstration can be analyzed, or does one "draw blueprints" so as to satisfy fully the dictates of pure research methodologies?

The policy which states the project is obligated to offer its services to all eligible referrals who need and will use project services was a determining force in deciding which analytical "posture" to take. It was expected that difficulties would be experienced in evolving an experimental system which was analyzable but, at the same time, not discriminatory toward clients. For example a control group would have denied some clients the full services needed for regaining independence. For this reason the decision was made to concentrate on developing a design which might improve predictive capability from evaluational research as well as reach the rehabilitation objectives heretofore identified.

Among the ten specific objectives proposed were a number having special relevance for evaluation research. The most salient of these objectives were:

1. Develop an adequate medical-psychological-social-vocational rehabilitation evaluation.
2. Compile and analyze data pertaining to the clients served, including their relationship to costs and results.
3. Appraise the usefulness of the project's methods.
4. Measure and evaluate results and causes for failures.

The problem of developing an adequate medical-psychological-social-vocational rehabilitation evaluation was perceived as being a key issue for design development. Inherent in this problem were thought to be the following questions:

1. What is an adequate medical-psychological-social-vocational rehabilitation evaluation?
2. Is it administratively and financially feasible to do a comprehensive evaluation on each referral and his family?
3. Who will do what portion of this evaluation?
4. How can the project effectively use SDPW-DVR personnel to meet this obligation?

5. How can the project effectively use consultant services to meet this obligation?

The approach was based on the premise that research should be utilized to develop an adequate evaluation. The project personnel assumed that development of a comprehensive client evaluation would be a lengthy and complex process.

For design purposes, the necessity of developing criteria for such an evaluation was deemed mandatory. Identification of as many variables as was possible and feasible received first priority. This "shotgun approach" was considered practicable with the use of factor analysis methodologies. By using factor analysis (see Chapter III, Section 9) reliability (and apparent validity) was anticipated through the reduction of a multitude of variables to some key predictors. It was expected that, if these predictors would predict the likelihood of success or failure, then inferences could be made regarding the adequacy of the evaluation process.

The second research phase included multiple linear regression analysis techniques so as to allow a comparison of success and failure cases. In order to accomplish this, variables which defined success and failure had to be found. A decision was made to use certain criteria from data reporting sheets (see Appendix A) previously developed by the Vocational Rehabilitation Administration, and that gainful employment would be the main criterion of success.

The following controls were included in the plan:

A. All referrals to the project would participate in the comprehensive evaluation process.

B. Persons to be referred for project services would be drawn from Bexar County recipients of, and/or applicants for Aid for Families with Dependent Children public assistance grants.

C. The upper age limit for referrals to the project would be 60 years.

D. Project activities would terminate if one or more of the following conditions were disclosed:

    1. a medically indicated terminal illness;

    2. confinement to an institution when confinement is expected to be of long or indefinite duration;

    3. medical evidence that any program of rehabilitation would exacerbate materially the individual's physical or mental condition;

    4. a combination of disabilities which would make the individual's vocational rehabilitation possibilities extremely

remote;

5. psychiatrically or psychologically diagnosed mental functioning at such a low or unrealistic level that rehabilitation possibilities would seem to be absent or extemely remote.

E. A parent population survey was conducted for the purpose of determining the extent to which referrals to the project were representative.

F. Prior to the use of evaluation criteria and success and failure criteria, consultant's (recognized experts) reviewed, edited, modified, and/or expanded the rating systems.

G. Who would do which ratings was specified.

H. No counselor or caseworker would have over 60 clients at any given time.

I. A follow-up study has been included in project plans for the purpose of validation of findings.

J. If a referred individual were continued by the project beyond the evaluation stage, he would be provided such intensive diagnostic and rehabilitation services as appeared appropriate in the judgment of the professional staff members.

Evaluation Criteria. At an early day-long meeting of the Project's professional staff together with the project's special consultants, decisions were made concerning the specific variables for which data should be acquired for each client with whom the project personnel worked. The Diagnostic Evaluation Format made provision for the recording of data pertaining to 50 separate variables in categorical form (e.g., Male or Female); as ratings on 9-point scales (e.g., "Time Management": Rating of "1" - Total misuse of time; Rating of "9" - Soundly preplanned time usage ...). The client variables assessed by the Diagnostic Evaluation Format for this project are named in Table 2, and the specific ratings can be found in Appendix A. The empirically developed scoring methods for the Work Attitude Scales are included; however, the scales are under copyright and the research involved in the development of these scales was not part of the project design.

Table 2

CLIENT DATA REQUIRED BY DIAGNOSTIC EVALUATION FORMAT (DEF)

Variables

I. Marker Information

1. Sex
2. Race or Ethnic Group
3. Religious Group and Particip'n
4. Housing Quality
5. Primary Language
6. Marital Status
7. Police Record
8. References
9. Work History
10. Prior Voc. Training
11. Previous Rehab. Experience
12. Telephone
13. Years in School
14. No. Dependents
15. $ Total Welfare
16. $ Monthly Welfare
17. Months on Welfare
18. Year of birth
19. Age in years

II. Appearance Ratings

20. Personal Hygiene
21. Clothing
22. Aesthetic

III. Physical Status Ratings

23. Oral Hygiene
24. Muscle
25. Bone
26. Respiratory
27. Cardio-Vascular
28. GI & GU Systems
29. Endocrine and Weight
30. Neurological
31. Vision
32. Hearing

Variables

IV. Mental Aptitude & Academic Ratings

33. Numberical
34. Verbal
35. General
36. Intellectual Function Level
37. Perception
38. Manual Dexterity

V. Emotionality Ratings

39. Projective Responses

VII. Attitude Ratings toward:

40. Family
41. Government
42. Training
43. Child Education

VIII. Family Status Ratings

44. Affection

Family Management of:

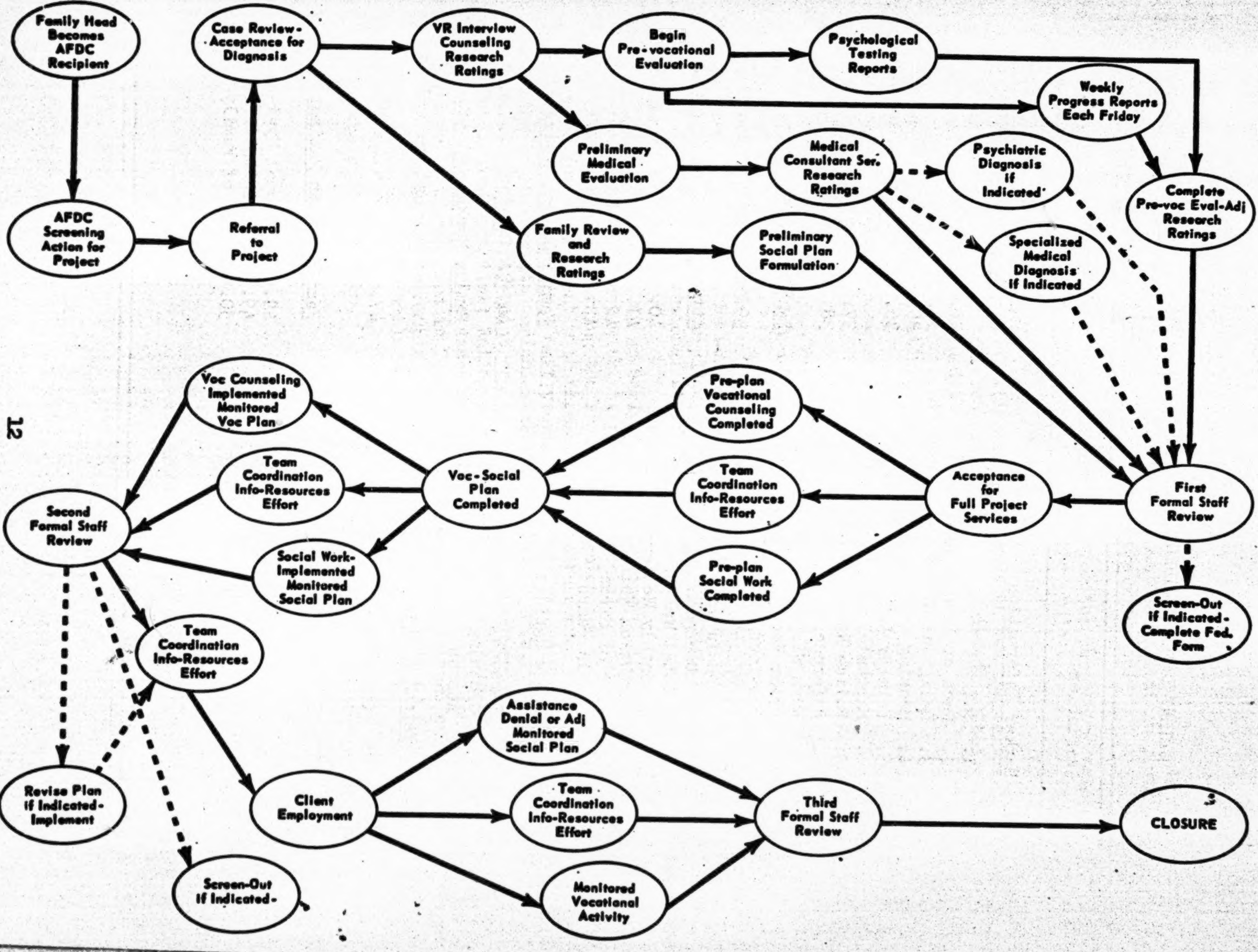
45. Money and Equivalent
46. Time
47. Resources for Recreation

Family Health Ratings

48. Individual Hygiene
49. Home Sanitation
50. Degree of Family Illness

WELFARE - REHABILITATION COOPERATIVE PLAN

CHART 1


Family Head Becomes AFDC Recipient
AFDC Screening Action for Project
Referral to Project
Case Review-Acceptance for Diagnosis
VR Interview Counseling Research Ratings
Begin Pre-vocational Evaluation
Psychological Testing Reports
Weekly Progress Reports Each Friday
Complete Pre-voc Eval-Adj Research Ratings
Preliminary Medical Evaluation
Medical Consultant Ser. Research Ratings
Psychiatric Diagnosis if Indicated
Specialized Medical Diagnosis if Indicated
Family Review and Research Ratings
Preliminary Social Plan Formulation
First Formal Staff Review
Screen-Out if Indicated-Complete Fed. Form
Acceptance for Full Project Services
Pre-plan Vocational Counseling Completed
Team Coordination Info-Resources Effort
Pre-plan Social Work Completed
Voc-Social Plan Completed
Voc Counseling Implemented Monitored Voc Plan
Team Coordination Info-Resources Effort
Social Work-Implemented Monitored Social Plan
Second Formal Staff Review
Team Coordination Info-Resources Effort
Revise Plan if Indicated-Implement
Screen-Out if Indicated-
Client Employment
Assistance Denial or Adj Monitored Social Plan
Team Coordination Info-Resources Effort
Monitored Vocational Activity
Third Formal Staff Review
CLOSURE

SECTION 6

COOPERATIVE PLAN

A plan for welding the routine policies and procedures of separate agencies into a compatible and effective project operational plan was esential to carrying out research and demonstration. With the cooperation of personnel at all levels, working guidelines were developed so that the efforts and resources of both agencies could be focused directly on the client and family. In addition to the routine specialized services of the parent agencies and the available community resources, several special features were set out. These included a team approach, intensive case service, prevocational evaluational adjustment services and the comprehensive client-family research evaluation and rating system. Essentially, the proposed cooperative plan centered point blank on the client and family with more and better coordinated services and attention than ever before.

The team approach was anticipated to provide better coordination of efforts and more effective service. Joint housing set the stage for this type of cooperation and was expected to educate counselor-caseworker teams in mutual problems. Individual team member goals were set out in appropriate functional tasks, as stated before, so that members would not lose identity as specialists in their fields. The team members were expected, however, to identify themselves completely with integrated client-centered team goals. Another way this concept has been so aptly stated is "complete dedication to serving the client and family."

Intensive case service was anticipated as another means to reduce some of the characteristic limitations of the AFDC clientele. Emotional disturbance, lack of confidence, self-esteem, passive resistance to change, and general lack of motivation indicated more contacts than usual would be necessary. No rigid guideline was established on the number of contacts because individual differences were so wide.

The prevocational evaluation-adjustment services and research ratings will be discussed later in the detailed explanation of the cooperative plan. At this point, it should be apparent to the reader that the application of the full spectrum of dual-agency (Project) services and activities is an extremely complex operation. Lack of proper timing alone could disrupt or terminate a rehabilitation plan. Because of the complexity of the task, a modified version of the Program Evaluation and Review Technique was used to illustrate graphically the Welfare-Rehabilitation Cooperative Plan.

The Cooperative Plan can best be described as a precise network of dual-agency functional activities designed to encourage and assist dependent people in realizing their potential in self-sufficient and independent living. Each ellipse shown on the plan indicates some event or functional activity. Starting from the event where "family head becomes AFDC recipient," the solid directional line represents an "action" line leading to the accomplishment of one or more succeeding events. Conditional events or functions which may or may not be appropriate in a given case are shown in dashed lines. Any given event or action is possible only after the indicated preceding activity is completed and its accomplishment automatically sets off subsequent activity along indicated lines of action. In order to appreciate the total involvement depicted by each activity line leading to accomplishment of an event, one must realize that a multitude of supporting details must be accomplished and that these details might be graphically expanded in a network as large as the basic plan. The cooperative plan will be discussed step by step with sufficient detail to give a reasonable picture of operational procedures.

SECTION 7

DEMONSTRATION PROCEDURES

The Case Cycle

When a family head met the welfare criteria for becoming an AFDC recipient, he or she was automatically eligible to be considered for referral to the Project. Approximately 10 to 25% of the 3000 plus AFDC recipients were men meeting the existing SDPW eligibility requirements for two-parent household "where...deprivation is established, the head of the household is unable to pursue a gainful occupation...." Male eligibility was established by the SDPW Medical Services Division. Eligibility for the female portion of the AFDC population was determined by the general caseworker on criteria other than medical, for example, death, desertion or incarceration of the father.

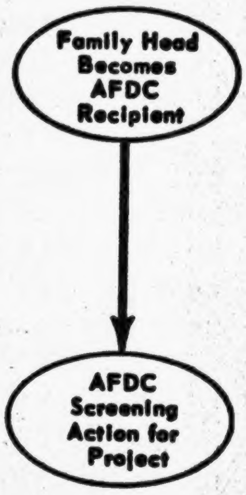

Family Head Becomes AFDC Recipient
AFDC Screening Action for Project

Figure 1

The regular caseworker was also responsible for making referrals to the Project and in this respect was a first line member of a team effort. For research purposes, the screening criteria for approximately a random sampling of the target population was limited by only two requirements. The client was required to be less than 61 years of age and have some apparent or assumed disability.

Referral to the Project was arranged through supervisory channels to the Project SDPW Supervisor and the case folder was sent on request to finalize the referral. Certain preparatory work prior to referral was considered as an inherent part of case work. This included medical reports for male recipients, male AFDC eligibility information, apprizing the client of opportunities, assessing cooperativeness, adequate depth to social study and good social summary.

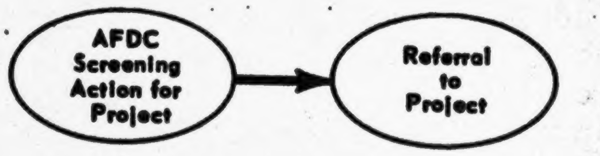


Figure 2

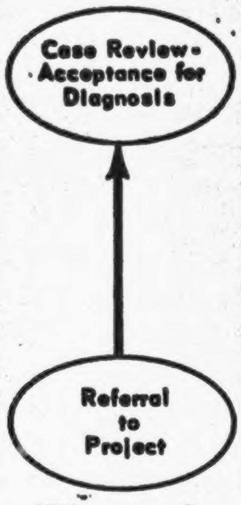


Figure 3

Case Review in the Project was accomplished by the SDPW Supervisor and Project Director. The main considerations were to review age, readiness, and compatibility of service with State law and agency policy. For example, a predominant visual disability of a specific severity must be referred to the Commission for the Blind, etc. In most instances, clients were scheduled for diagnostic services. Team assignments were made and afterwards the SDPW secretary initiated each appointment letter after coordination with the counselor and caseworker involved. In practice the caseworker established rapport with the client and then introduced the person to the counselor for initial DVR interview and counseling.

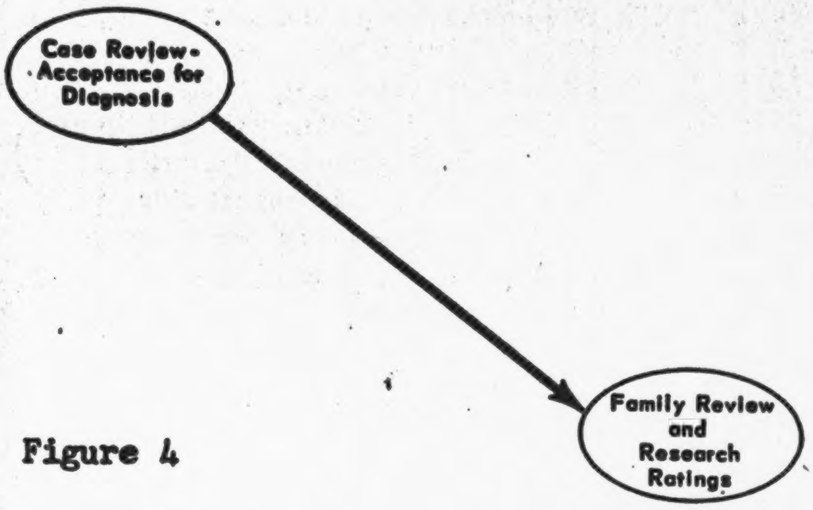

Case Review-Acceptance for Diagnosis
Family Review and Research Ratings

Figure 4

Family review and research ratings were accomplished simultaneously with other diagnostic procedures. Timing was important in that the home review was planned to be no later than ten days after the client started prevocational classes. (Research ratings at a later time could be affected by class attendance.)

In addition to, and along with, routine social diagnosis, assessments and recording, the caseworker obtained marker data and evaluated the family using research variables on the Diagnostic Evaluation Format as follows: (4) Housing Quality (7) Police Record (14) Number dependents (15) Total Welfare (16) Monthly Welfare (17) Months on Welfare (43) Child Education (44) Affection (45) Money and Equivalent (46) Time (47) Resources for Recreation (48) Family Hygiene (49) Home Sanitation (50) Degree of Family Illness. Introduction of training and strict adherence to the elements of the rating shown in Appendix A was expected to give adequate caseworker standardization. In-service training was accomplished to maximize standardization.

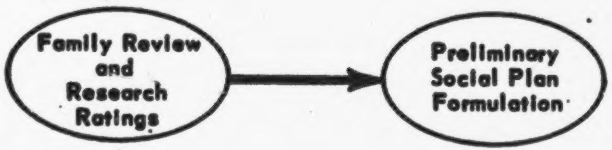

Family Review and Research Ratings
Preliminary Social Plan Formulation

Figure 5

Preliminary social plan formulation was one logical outcome of the family review. After strengths and weaknesses were assessed, the social plan for helping the family was set out to include a social diagnosis and objectives for helping the family live more effectively. One very important consideration in evaluation and planning was the family influence on the potential breadwinner in regard to work. The preliminary social plan was important for initial work with the family and as a basis for re-evaluation to determine improvement.

Along with social services, case review and acceptance initiated another chain of activity. As shown in Figure 6, diagnostic services were simultaneously provided by the caseworker and counselor team.

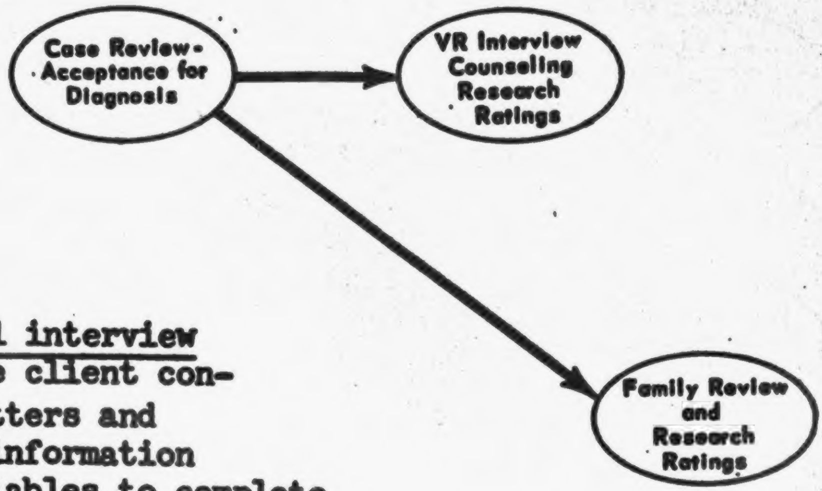

Case Review - Acceptance for Diagnosis
VR Interview Counseling Research Ratings
Family Review and Research Ratings

Figure 6

The VR counselor's initial interview and counseling session with the client concerned productivity-related matters and included the necessary marker information and assessment of research variables to complete part of the (DEF) Diagnostic Evaluation Format (see Table 2). These items were: (1) Sex, (2) Race, (3) Religious Group and Participation, (5) Primary Language, (6) Marital Status, (8) Reference, (9) Work History, (10) Prior Vocational Training, (11) Previous Rehabilitation Experience, (12) Telephone, (13) Years in School, (18) Year of Birth, (19) Age in Years, (20) Personal Appearance, (21) Clothing, (22) Aesthetic, (40) Attitude Toward Family, (41) Attitude Toward Government, and (42) Attitude Toward Training. Care was exercised by the counselor to be as objective as possible in evaluating each client. Strict adherence to the rating scales shown in Appendix A was expected to give adequate counselor standardization after introductory training. Discussion of standardization in Staff meetings was accomplished as necessary.

Counseling was conducted using the most appropriate technique for each client. The goal was to establish good rapport, to learn as much as possible about the client, offer encouragement and necessary guidance, help the client perceive his problem areas, and assist him in planning. In the first session, the client was offered the opportunity to attend classes with transportation furnished. This was a crucial point because lack of cooperation for no reasonable cause was a usually clear indication of a hardcore dependent case. If considerable urging on the part of the counselor-caseworker team did not inspire the person to participate, the case was screened out as an unsuccessful referral.

During initial contact with the client, the counselor initiated action toward acquiring a general medical examination and certain special medical examinations and arranged for the client's entry into prevocational classes as part of a comprehensive plan of evaluation.

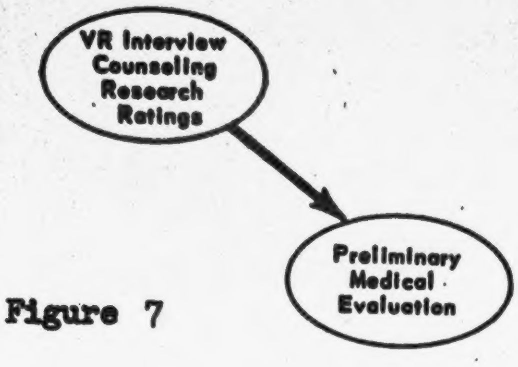

VR Interview
Counseling
Research
Ratings
Preliminary
Medical
Evaluation

Figure 7

Preliminary medical evaluation from the general and other medical reports was carried out by the counselor and any necessary notes were prepared to help in discussing the case later with the medical consultant. Copies of all medical reports were given to the caseworker for coordination with the DPW medical eligibility board.

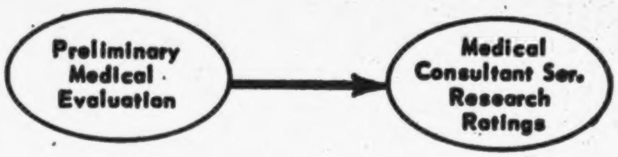

Preliminary
Medical
Evaluation
Medical
Consultant Ser.
Research
Ratings

Figure 8

On an appointed day each week, Dr. Schauer, medical consultant, arrived to review all cases having new medical information. The general and any specialist examination reports were analyzed for significance. Based on findings, a numerical research rating was given for each of ten areas. The areas included (23) oral hygiene, (24) muscle (including hernia), (25) bone, (26) respiratory, (27) cardiovascular, (28) GI and GU systems, (29) endocrine and weight, (30) neurological, (31) sight, and (32) hearing. Ratings were given on a nine-point scale for each condition and entered on the (DEF) Diagnostic Evaluation Format in preparation for research analysis (see Table 2). Rating scales are shown in Appendix I.

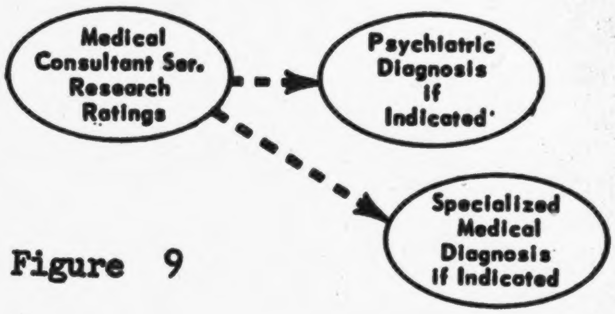

Medical
Consultant Ser.
Research
Ratings
Psychiatric
Diagnosis
If
Indicated
Specialized
Medical
Diagnosis
If Indicated

Figure 9

Special diagnoses were obtained by the counselor as necessary for good evaluation. The medical consultant's recommendations were used as a guide in all evaluational considerations. Goals included obtaining diagnostic information justifying eligibility and obtaining information relative to needs in restoring the individual to productivity.

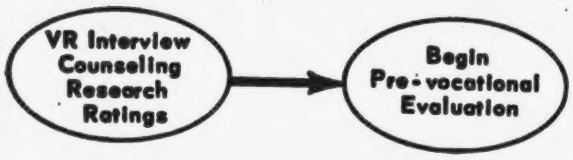

VR Interview
Counseling
Research
Ratings
Begin
Pre-vocational
Evaluation

Figure 10

The client entered prevocational evaluation-adjustment classes according to plans worked out in the initial interview and counseling session. It was understood that the classes represented an opportunity to prepare for vocational activity. Bus tickets were furnished to help candidates take advantage of the opportunity, but no other monetary inducements were offered. When family-related problems, such as child care, threatened plans, the caseworker assisted the client in working out some solution. All clients were required to attend prevocational classes, except in cases where this was impractical for good reason. Classes were conducted five days per week from 8:00 A.M. to 2:30 P.M.

The evaluation-adjustment goal was to assess the individual's academic, personal, and inter-personal response and performance levels. The most effective evaluation was expected to result from actual exposure and response to a curriculum of experiences, to a group or groups of people, and to facsimile and real-life situations. The curriculum is given in Appendix B and the details are also discussed more fully in Chapter 4 , Section 12.

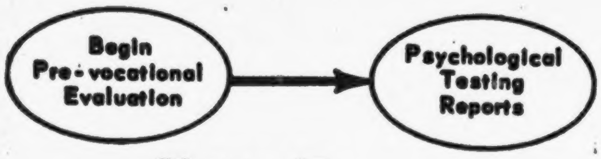

Begin Pre-vocational Evaluation
Psychological Testing Reports

Figure 11

There were five tests administered by Dr. Rast, Project Psychological Consultant, to each client during the initial days of prevocational activity. Selection of tests to be administered was based upon considerations such as adequacy of characteristics measured, reliability and validity of measurements, and utility of measurement devices. Non-verbal tests were selected in view of average client's lack of reading ability and the illiterate. The five tests selected were (1) Group Rorschach; (2) The Revised Beta Examination; (3) Memory-For-Designs Test (Graham-Kendall); (4) Purdue Pegboard, a test of manipulative dexterity and (5) The Work Attitude Scale. Results of these tests were documented for each individual and used clinically in counseling. The results were also introduced with other information for computer processing and research analysis.

The Rorschach was administered in group form following Harrorer's directions and the score was identical to her method. The Group Rorschach form and scoring key are shown in Appendix A. The total score on a Group Rorschach was used as an index of pathology. The minimum score possible is 30; the maximum score is 300. Therefore, the higher the score, the greater the indication of pathology.

The Revised Beta Examination was administered using the standard procedures following Lindner-Gurvitz Standardization. This test is considered to measure intelligence and has similar meaning to Wechsler-Adult Intelligent Scale. Therefore, a person obtaining a Beta IQ of 100 is considered average.

The test Memory-For-Designs was administered and the standard administration and scoring was followed. This test is considered to measure perceptual and motor skills. Interpretation of the score was accomplished similar to the interpretations in the Monograph Supplement 2-VII 1960. The general interpretation was, the higher the score, the greater the chance of visual motor disturbances and possible brain damage.

The Purdue Pegboard is a test of manual dexterity. The administra- and interpretation and norms are the same as the norms by the Science Research Associates. The main indication is, the higher the score, the greater amount of manual dexterity the individual possesses.

The scores on all tests were converted to a nine-point scale as shown in Appendix A. In order to develop the nine-point rating scale, the minimum and maximum scores obtainable on each test were considered the limits. Each point on the nine-point scale represented a proportionate increment of the raw score. The lowest of the ratings, number one, was considered the poorest rating possible. As an example, on the Revised Beta Examination, a rating of one revealed that the person obtained the lowest possible score on this exam. All other ratings of one were identically interpreted. The highest rating possible on each scale was nine and represented the best score obtainable. The following example illustrates a battery of individual scores for general interpretation rather than clinical application. CLIENT "A": Emotional Stability (Rorschach), 4; Dexterity (Purdue Pegboard) 9; Intellectual Functioning (Revised Beta) 5; and Perception (Graham-Kendall) 7. To illustrate scoring and interpretations, a person scoring 170 on the Rorschach would obtain a rating of four; a score of 51 on the Purdue Pegboard would obtain a rating of nine; an IQ of 79 on the Revised Beta would give a rating of five; and a score of 11 on the Graham-Kendall would indicate a rating of seven. Thus, it could be generally interpreted to mean this individual would be considered to be emotionally unstable, limited in his intellectual abilities but with excellent manual dexterity. In counseling, knowledge of these factors would assist in determining the most suitable occupational objective.

The Work Attitude Scale was administered to each client on an experimental basis. Attempts were made to determine the individual's general attitude toward work vs. dependence and other considerations. See Appendix "C" for an analysis of the Work Attitude Scale.

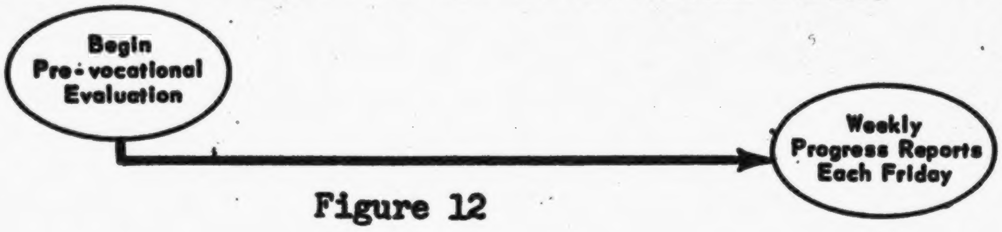
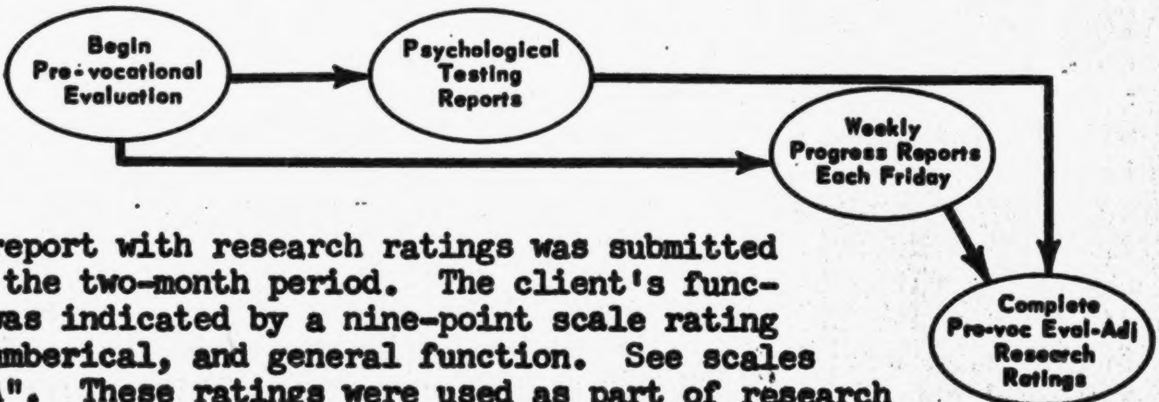

Begin Pre-vocational Evaluation
Weekly Progress Reports Each Friday

Figure 12

Weekly progress reports on a day-by-day basis were an essential part of systematic feedback to the counselor-caseworker team. The reports were scheduled to be in the Project office on Friday afternoon for that week. The reports were posted on a specially marked clipboard for use of team members. The progress on class objectives and the casual but significant remarks included in the daily reports served to alert team members to any immediate and/or future needs for services. It was expected that group conversation would bring out highly significant information about family conditions, attitudes, handicaps, and self concept which could be useful to team members in helping the client and family.

Figure 13


Begin Pre-vocational Evaluation
Psychological Testing Reports
Weekly Progress Reports Each Friday
Complete Pre-voc Eval-Adj Research Ratings

A final report with research ratings was submitted at the end of the two-month period. The client's functional level was indicated by a nine-point scale rating for verbal, numberical, and general function. See scales in Appendix "A". These ratings were used as part of research data collected on the DEF (see Table 2) and the counselor used the information in the rehabilitation program.

Benefits from prevocational class activity were expected to be very significant in working with an AFDC clientele. In addition to evaluation, a concomitant gain in academic ability and social adjustment was anticipated for all who cooperated by attending classes.

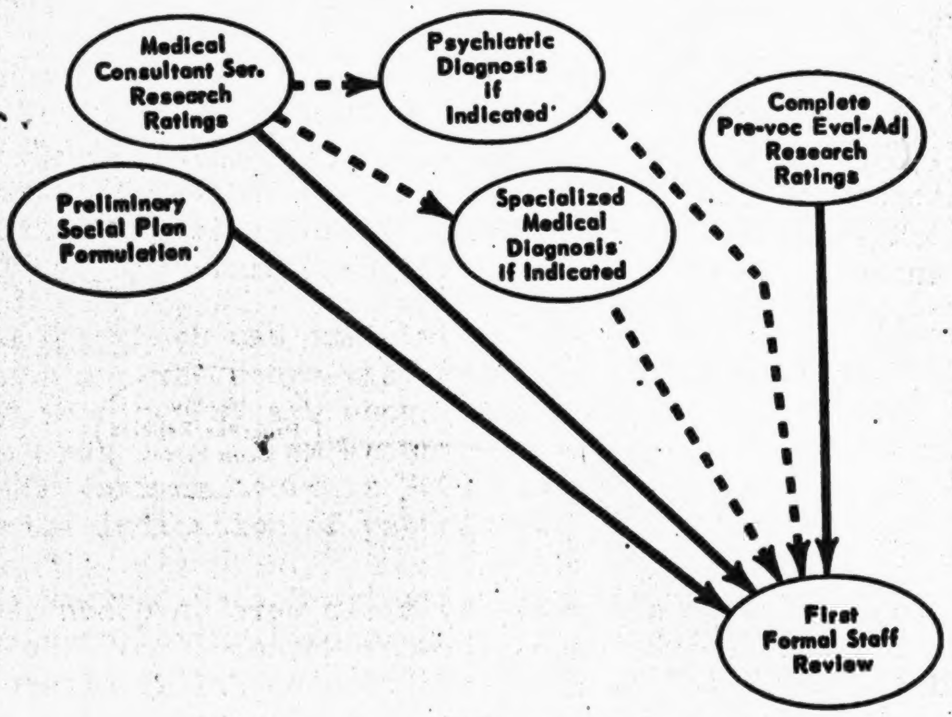

Medical Consultant Ser. Research Ratings
Psychiatric Diagnosis If Indicated
Complete Pre-voc Eval-Adj Research Ratings
Preliminary Social Plan Formulation
Specialized Medical Diagnosis If Indicated
First Formal Staff Review

Figure 14

The first formal staff review in each case was held to finalize the decision to screen out the client or accept him for full project services. This event occurred after all types of diagnostic information has been collected, studied and used as the basis for determining eligibility. A codable medical disability with resultant vocational handicap was combined with all other associated disabling conditions to constitute what was termed a constellation of disabilities. At this point each case had been in constant informal review by team members, which had usually resulted in a joint decision pending formal review. The formal staff review was conducted with the team members, SDPW Supervisor, and VR supervisory representative present. After a brief discussion of the salient facts in the case, a team decision was expressed. The facts and decisions were reviewed concurrently from a policy standpoint by the supervisory personnel.

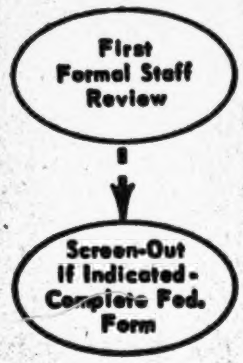

First Formal Staff Review
Screen-Out If Indicated-Complete Fed. Form

Figure 15

In cases where the client could not be expected to benefit significantly or where he could not participate, the case was closed out of the Project. Depending on the nature of the case, the folder was returned to the SDPW district office for continued services or was denied on justifiable grounds. When a case was screened out of the Project after the first staff review, Data Sheet number one (see Appendix "A") was accomplished for research purposes.

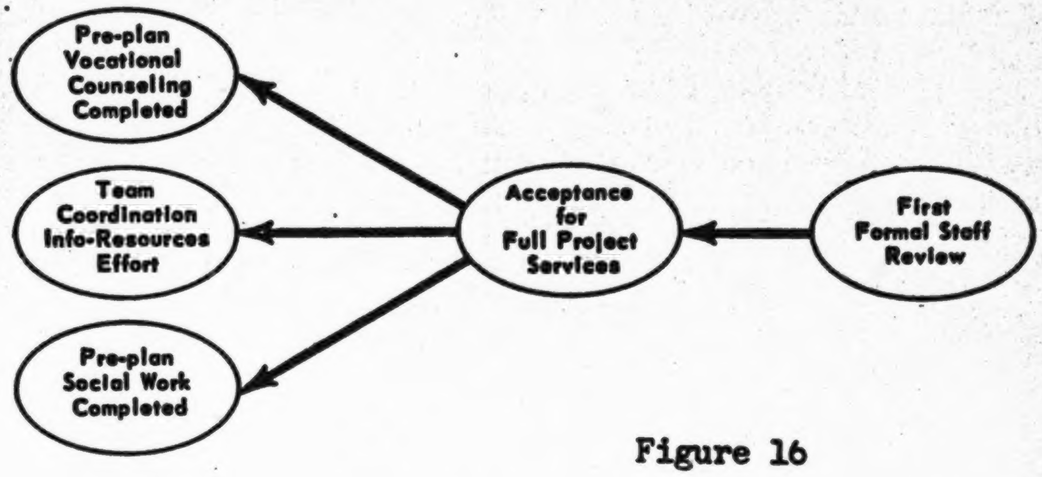

Pre-plan Vocational Counseling Completed
Team Coordination Info-Resources Effort
Pre-plan Social Work Completed
Acceptance for Full Project Services
First Formal Staff Review

Figure 16

Acceptance for full project services set the stage for increasing intensive case services close on the heels of class activity. Vocational counseling and social case work preparatory to establishing a comprehensive vocational-social rehabilitation plan were carried out systematically. The counselor used client and environmental information developed in the diagnostic phase of services to help the client perceive and plan to take advantage of optimum opportunity. The caseworker used family and environmental information as a basis for helping the family perceive opportunity and develop solid home support for better living standards. A close counselor-caseworker team relationship was demonstrated to clients as each member coordinated activities and cared for his functional responsibilities. The degree to which the client perceived himself a third member of the team was expected to strengthen the effectiveness of overall team action.

A comprehensive vocational-social plan was finalized after diagnostic information was used as a basis for counseling and social case work. The plan was in two parts and included the counselor's regular vocational information and the caseworker's social plan for helping the family solve problems and for strengthening family support of the client in training. Team coordination of information, resources, and effort played an important part in establishing a vocational plan of sufficient duration to reach the established objective. This was particularly important in

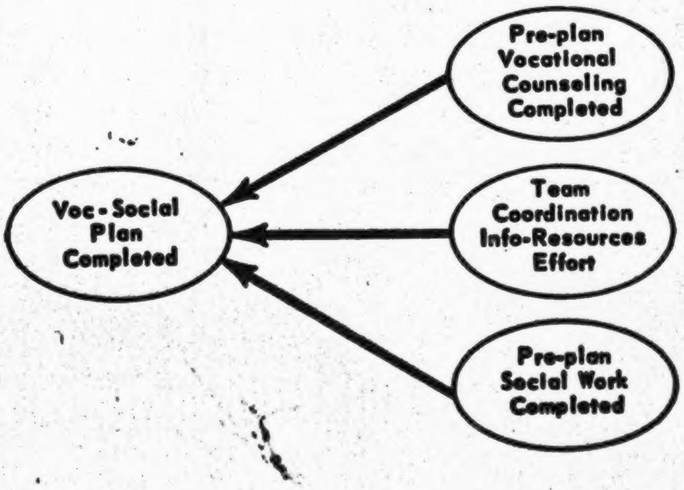

Voc-Social Plan Completed
Pre-plan Vocational Counseling Completed
Team Coordination Info-Resources Effort
Pre-plan Social Work Completed

Figure 17

cases involving long physical restoration services and periods of training where the AFDC grant furnished the assurance that the family would be cared for until employment and independence materialized. In addition to the team work on the front line, the caseworker had the responsibility of keeping the Medical Determination Board at the State Office informed of the plans for male clients. The male client's tenure on public assistance was subject to review by the Board, and without good coordination, it was possible that assistance could be terminated in the middle of a vocational plan.

The client's plan focused all resources and efforts toward reaching his optimum objective. It was enhanced by results of the prevocational adjustment period and the countinuing efforts of team specialists in counseling and social case work. The plan included all details considered necessary for successful completion.

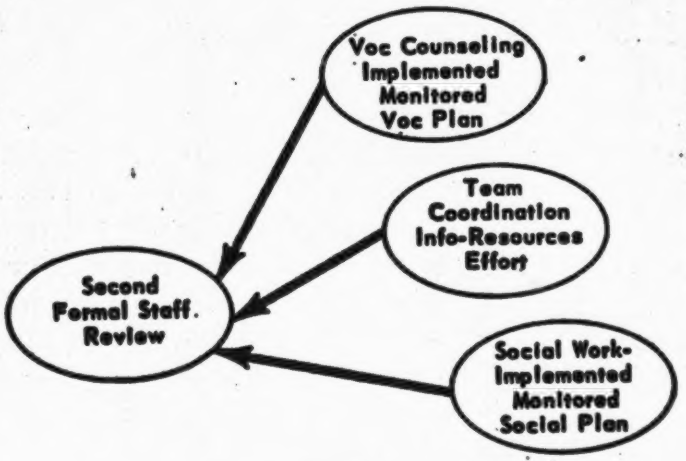

Voc Counseling
Implemented
Monitored
Voc Plan
Team
Coordination
Info-Resources
Effort
Second
Formal Staff.
Review
Social Work-
Implemented
Monitored
Social Plan

Figure 18

A second formal staff review was held at a time when the degree of success could be evaluated, deficiencies spotted, and any remedial or helping action could be planned. The review followed implementation of the vocational plan, social plan, and sufficient team monitoring - coordinating activity to properly assess progress. During this phase of case services, team members were watchful for signs of disenchantment or other obstacles which might forecast difficulty in completing the plan.

In some cases through no fault of the client, it was expected that previously unknown factors might exert adverse influence on the plan. Vocational factors such as allergies to paints, and plastics could become an obstacle to the original vocational plan. At times developments of a social nature such as sickness in the family or breakdown in child care might make changes in the plan necessary. In such cases action shown along the dashed line was taken to revise the plan. The revised plan was accomplished and implemented with the same painstaking care as the original to assure a reasonable expectation of success. After plan revision, the team continued working closely with the client and family coordinating information, resources, and efforts.

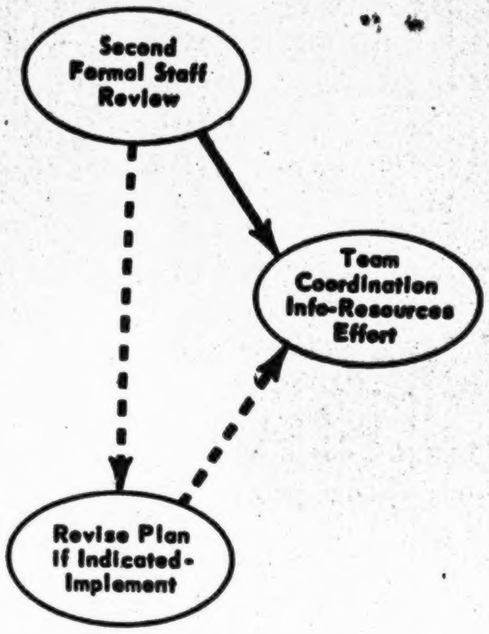

Second Formal Staff Review
Team Coordination Info-Resources Effort
Revise Plan If Indicated-Implement

Figure 19

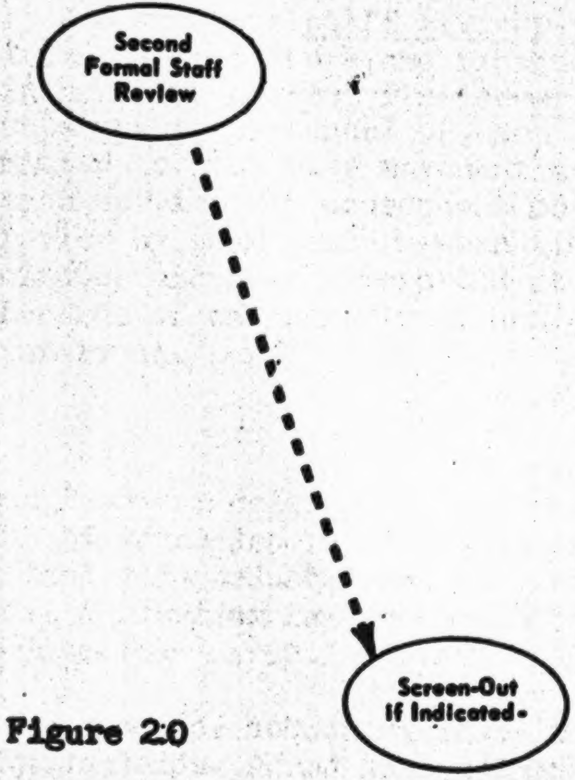


Figure 20

In some cases the review indicated that there was no reasonable expectation of the client being successful in the on-going plan or in eventually becoming independent. The range of expected reasons was wide but underlying resurgent dependency reflected by loss of motivation and lack of cooperation was anticipated as a major cause for failure. In cases where there was a chance for remedial action the decision for "screen-out" was delayed pending results of last ditch efforts. In cases where progression of the disease or a new medical involvement was a factor, medical attention and advice was used as a basis for decision. Screen-out at this point represented a failure case for rehabilitation, and depending on the circumstances, the welfare grant was denied or the case transferred back to the regional office for continuance.

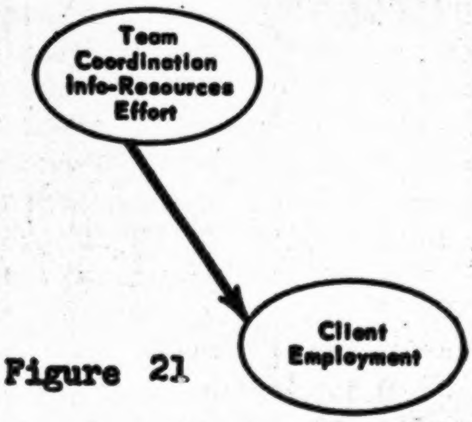

Team
Coordination
Info-Resources
Effort
Client
Employment

Figure 21

Employment was considered a significant milestone on the road to better living and independence. A healthy attitude toward employment and work had been cultivated in the client during prevocational adjustment classes, counseling sessions and through family case work. Public assistance and appropriate vocation-enabling help such as physical restoration, prostheses, orthotic devices, training, tools, and placement assistance were instrumental in his ability to accept the opportunity. Yet because a significant number of clients had not engaged in permanent employment for years and some never before, it was anticipated that the average case would be in its most critical stage.

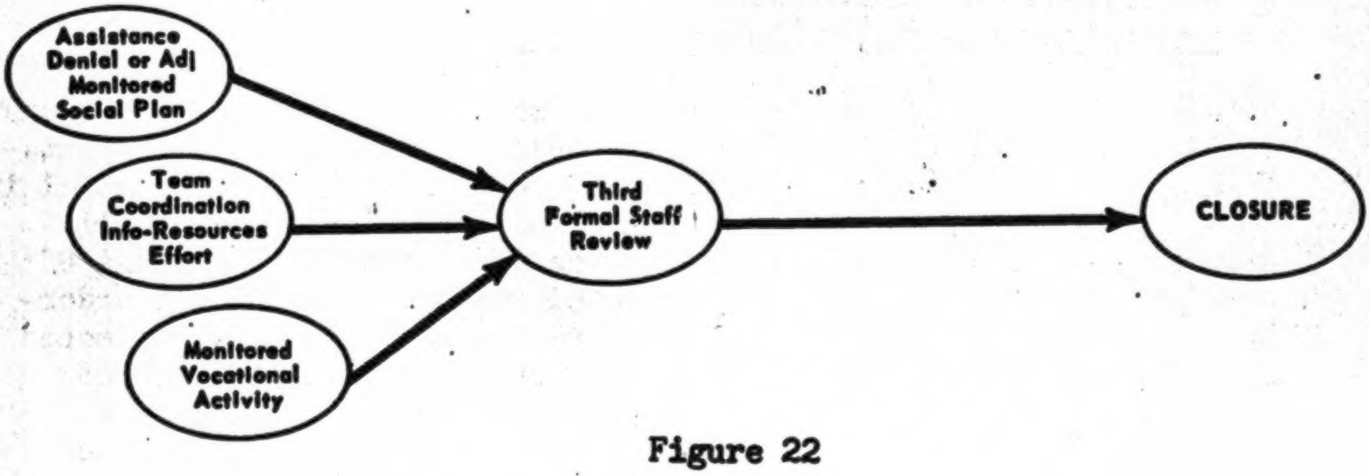

Assistance
Denial or Adj
Monitored
Social Plan
Team
Coordination
Info-Resources
Effort
Monitored
Vocational
Activity
Third
Formal Staff
Review
CLOSURE

Figure 22

Team monitoring during the employment stage of the plan was designed to search for clues to maladjustment or incompatibility that might threaten to disrupt the client's plan for the future. It was expected that family flare-ups, intercurrent illnesses, unexpected events, and motivation letdowns would be among the factors to watch for and treat.

After the client had been in successful employment for at least one to three months and when the conditions were assessed to be satisfactory, a third and final staff review was scheduled. The conditions of employment, and home and family relations were reviewed in regard to the degree of success acheived. At this point, where the decision was favorable, the caseworker made plans for denying the grant and the counselor initiated closure action. In the case of women whose family size and wage potential left an unmet need, enough grant was retained to supplement the earnings, and the case was transferred to the SDPW Regional Office for continuance.

In the event that the decision on vocational success was not favorable and there was no reasonable expectation that a revised plan would succeed, the case was closed as unsuccessful. In such an event the caseworker reviewed the circumstances before either denying the case or transferring it for continuance.

Operational Controls

In addition to the respective agency case control measures, certain simple yet effective operational control measures were established to guide Project personnel in working together. It was anticipated that the coordination so effected might help move the joint cases smoothly.

The Diagnostic Evaluation Format was one of the first control devices—a form on which diagnostic research data were accumulated from the various sources.

An operations wall board was used to record names of all clients jointly served along with operational and research data. The operational data included date of referral, period of prevocational classes, date and results of first staff review, vocational objective, dates and results of second and third staff reviews, and closure information. The research data were mostly in the coded form of scale ratings.

Systematic staff reviews were expected to climax specific phases of intensive team work and provide a means for recording mutual decisions in handling cases. It also provided a means of interpreting policy by supervisory personnel of each agency. This control measure was not permitted to slow case movement as it might under rigid application. Needed case service and consequent movement was conducted after informal staff review by team members when time was of the essence. The action and circumstances were reported at the next scheduled formal staff review. Records of cases reviewed and actions taken were accomplished for reference.

Handling the Research Data

A research folder was prepared for each client referred to the Project. The folder contained the Diagnostic Evaluation Format and the completed Work Attitude Scale. After the DEF was completed in entirety, the folder was forwarded to the Research Consultant where the data were punched on cards for processing.

When each cooperatively served case was closed, the appropriate Federal data forms were accomplished. If a case was closed from referral, "Data Sheet 1, Referral" was the only form completed. When a case was closed for any reason after acceptance, both Data Sheets 1 and 2 were completed. (See data sheets in Appendix "A".) Appropriate forms for each case were forwarded to the Research Consultant for card punching and processing.

Responsibility for the data processing and evaluational research was given to the Project Research Consultant. His willing acceptance of these responsibilities was largely due to the nature and timeliness of this

Project. Recent trends in our society have made opportunities such as this an important social challenge of our time. His response to this challenge has lead to the informative contents of the next chapter and part of Chapter IV.

CHAPTER III

EVALUATIONAL RESEARCH

SECTION 8

INTRODUCTION TO EVALUATION RESEARCH

The executive and legislative branches of the federal government have committed the United States to a "war against poverty." And inevitably, if perhaps prematurely, the predictable questions long associated with warfare are beginning to be asked. Are our campaigns succeeding or failing? Are we losing or winning the key battles?

It is a curious matter that we seem to find military metaphors peculiarly apt when we initiate new social welfare programs. We attack poverty in Appalachia (and elsewhere), and we zero in on the problem of cultural deprivation in childhood. Curious or not, however, military metaphors, as Miller (1965) has observed, can be useful to us if we keep it in mind at the same time that our real aims are those associated with creating and building rather than with destruction.

As dependable intelligence reports are needed for a campaign as well as for a single battle, so too is "intelligence" needed in regard to social planning and social action. In the latter arena, however, intelligence and feedback go by a different name: evaluation research. Evaluation research is concerned with such questions as (1) What is the program accomplishing? (2) Is it getting done what it was intended to do? (3) Is new information being acquired? (4) Can the information that is being sought and gained be applied in determining new goals and/or practices?

Studying Social Action and Change

The clients of social agencies typically receive multiple (and different) services from multiple sources, and this very fact creates substantial difficulties for evaluation research which seeks to find out "what factors brought about what changes in what people?" These difficulties are not insurmountable, albeit they may introduce major complications into the design of evaluation research. One way around some of these difficulties is to study the influence of a specific program on the individuals who comprise the particular population toward which the program is directed. To conduct such research adequately generally necessitates several kinds of investigation, which may include:

(1) the accumulation of descriptive data concerning the program itself;

(2) the conduct of surveys of client experiences, attitudes, and activities and of how these change across time;

(3) *prediction research* in which important *criterion changes* in individuals (and/or groups)—occurring *subsequent to* their participation in a given program—can be "explained" in terms of data available *prior to* their participation in a social action program;

(4) *inter-agency studies* including studies which illumine the relationship of the research itself to other agencies in the community.

SECTION 9

EVALUATION RESEARCH ON SAN ANTONIO'S REHABILITATION-WELFARE DEMONSTRATION AND RESEARCH PROJECT

Specific Objectives. Among the ten specific project objectives proposed were a number having special relevance for evaluation research. The most salient of these objectives were:

1. to establish a systematic means of identifying AFDC applicants or recipients who are potential candidates for rehabilitation;
2. to develop an adequate system for the medical, psychological, social, and vocational evaluation of these individuals;
3. compile and analyze data pertaining to the clients served by the Project, including their relationship to costs and results;
4. appraise the usefulness...of the Project's methods...;
5. ...measure and evaluate results (and) causes for failure....

Special emphasis was placed, in the initial project plan, upon the "thorough diagnosis...of each person served—including comprehensive medical, family, social, psychological and vocational appraisals— as a basis for determining needs for counseling, training, job placement, family services, and the like. Various criteria were developed to control referrals to the Project—*e.q.*, no person over 60 years of age would be referred—and to control whether or not a referred client should be worked with beyond "the preliminary evaluation" (*e.q.*, "medical evidence that any program of rehabilitation would materially exacerbate the individual's physical or mental condition"). If a referred individual were continued by the Project beyond the preliminary evaluation, he would be provided such intensive diagnostic and rehabilitation services as appeared appropriate in the judgment of competent professional staff members.

Specific Data Sought

Data on Clients. Evaluational criteria consisted of two types as determined by time and results of the case history. These criteria could be described as the preliminary diagnostic information on which prediction and case services might be based, and after-the-fact criteria available at closure from which the criterion of success must be drawn.

The preliminary information was accumulated on the Diagnostic Evaluation Format and by July 10, 1965, 113 cases were completed. These data were made available for analysis to the consulting staff of the Personnel Services Research Center at the University of Texas in Austin, and were processed by means of standard statistical methods.

Data on Parent Population. Because the sample of clients referred to and accepted by the San Antonio Welfare-Rehabilitation Project might prove to be unrepresentative of the total population of active welfare recipients from which it came, it was decided to obtain certain data for a sample consisting of every third case on the active rolls of the Welfare Department in March, 1965. Subsequently, preliminary comparisons of the Project sample (N=113) with this larger (N=614-728) sample population were made on these characteristics. The characteristics on which these comparisons were made were:

1. Sex of client
2. Race-Ethnicity
3. Years of Schooling
4. Police Record
5. Telephone Listing
6. Age of Client - Years
7. No. Dependents

SECTION 10

QUESTIONS, METHODS, AND RESULTS OF PRELIMINARY EVALUATION RESEARCH ANALYSES

In the previous section of this Report, the general and more specific purposes, and the data obtained in the San Antonio Welfare-Rehabilitation Project, were briefly described. In the present section, we shall present three things:

1. questions which could be asked, and tentatively, answered on the basis of diagnostic data available fr the first

113 clients examined by the Project's staff;

2. methods employed to elicit tentative answers to these earliest researchable questions;

3. results obtained in analyses directed toward answering these earliest salient questions.

HOW DID THE PROJECT'S CLIENT SAMPLE COMPARE WITH THE POPULATION OF WELFARE CLIENTS FROM WHICH IT CAME?

Evaluation research concerned with social action should produce results which can be generalized to the basic population from which the sample originally came. A weaker, but often necessary alternative, is, first, to determine the characteristics of the sample clientele and to caution all concerned that they should not generalize the findings to any populations which differ significantly from the one which has been studied. Our point here should not be missed--it is extremely important to discover the extent to which the clientele worked with are similar to the basic pool of clients.

The clientele being worked with by the present Project were not referred completely at random. Referred clients routinely showed, for example, some degree of disability; they were receiving AFDC grants; and, often, they had been receiving public assistance for very extended periods of time. It is perhaps likely, also, that those clients referred for rehabilitation in the earliest months of the Project may have been predominantly those whose rehabilitation prospects were least favorable.

The results pertaining to the question here at issue are shown in Table 3. Obviously the Project's sample has tended to be composed overwhelmingly and understandably of men, while the basic population consisted of women to the same extent (90%) as the Project sample consisted of men. Clearly, this difference between sample and population is a statistically significant one, and the Project's sample is unrepresentative of the Welfare Department's clientele with regard to sex.

When racial-ethnic group identification is concerned, the present Project's initial 113 clients were relatively over-loaded with Mexican Americans, and showed an underrepresentation of Negro Americans.

Manifestly, the Project's sample has been somewhat different from the Welfare Department's population where client police records are concerned, apparently having a larger representation of misdemeanors recorded against it and fewer individuals without police records than did the basic population. It also appears (Table 3) that the Project's sample averaged 1½ years older chronologically, had more dependents, and tended to be somewhat better educated (in terms of years of formal schooling) than did the base population.

Overall, the Project's model client it appears, could be described

TABLE 3

COMPARISONS OF PROJECT CLIENTELE (N = 113) WITH ONE-THIRD SAMPLE FROM WELFARE POPULATION (N's = 614-728)

Comparison Variables	Client Sample (N = 113)	Welfare Sample Population (N = 614-728)
A. **Sex**		
Males	90%	10%
Females	10%	90%
B. **Race-Ethnicity**		
Anglo-American	3%	4%
Latin-American	90%	75%
Negro-American	7%	20%
Other	—	1%
C. **Police Record**		
Felony	3%	5%
Misdemeanor	16%	5%
None	81%	90%
D. **Telephone**		
Yes	26%	28%
No	74%	72%
E. **Years of Schooling**		
9 or more	25%	21%
6-9	35%	30%
Under 6	40%	49%
F. No. Dependents	Mean = 5.17	4.19
G. Age in Years	Mean = 38.6 S.D. = 10.0	37.00 10.47

as a 38½-year-old male Latin American, with less than six years of schooling, having five dependents, but lacking a telephone and a police record.

What Were The Predictor Factor-Variables in the Diagnostic Evaluation Format?

Before even a tentative answer to the above question is attempted, the reader will do well to recall (1) the specific Project objectives reviewed earlier and (2) that some 50 potentially diagnostic or predictive variables were assessed for each client (See Table 2, Page11). It should be noted carefully that among the Project's objectives there appeared such statements as:

(a) compile and analyze data pertaining to the clients served...;

(b) develop an adequate (and, presumably economical) system for the medical, psychological, social, et al., evaluation of these individuals;

(c) establish a systematic means of identifying...potential candidates for rehabilitation;

(d) measure and evaluate results and causes for failure.

Identification, Diagnosis, and Prediction. It can be argued quite cogently that the identification of likely candidates for rehabilitation means that certain data are obtained for each individual which suggest, predict, or "diagnose" him to be a "good risk." Implicit in all four of the objectives listed on page   is the notion that, if we can spot the person with "the right pattern" of attributes (in "the right degree"), we are likely to be more accurate diagnosticians, or predictors of "rehabilitatableness."

As a first step in determining which characteristics might be most diagnostic (or predictive) of "rehabilitatableness," it was considered wise to obtain for each referred client a wide array of measures and judgment-based ratings of his medical, social, educational and other characteristics. Then, after our very best had been done to rehabilitate each, and we had later judged, or measured, the relative success or failure of his rehabilitation, we could relate our early observations in each case to its apparent outcome.

The sequence of activities just described requires, of course, a determination of which "early observations" (measures, ratings, examinations, etc.) show the highest predictive relationships to the desired outcomes. In other words, an assessment is needed of what factors are most strongly correlated with, or best predict, the criterion in which we are interested.

Leaving aside, for the moment, the important question of what constituted a satisfactory criterion indicator of any individual's relative success (or failure) in rehabilitation, we turned first to a consideration of those factors (medical, social, or other) which might augur in advance for the relative success or of the clients rehabilitation. We searched for the smallest, most economical and effective, and least redundant set of diagnostic (or predictive) factors.

The Diagnostic Evaluation Format used in the present Project was presumed to elicit measures, or ratings, of some 50 variable characteristics (Table 2) of clients, not including whatever attitudinal or motivational variables may be measured by the Work Attitudes Scales (WAS). But the question immediately confronted asked if, indeed, 50 separate characteristics were actually being assessed. Was it possible, for example, that these 50 variables might somehow represent only a "baker's dozen," perhaps, of more basic attributes?

The Concepts of "Correlation" and "Factor"

Correlational and factor-analytic methods have been extensively used in the biological and social sciences since the latter part of the 19th Century. They permit an examination of the associations between measures, or ratings, of individuals such as will yield a smaller set of measures which may gain us nearly as much information about each person as does an initially larger series of measures, examinations, or ratings of these individuals. To show these methods and concepts more clearly, a simple illustration is provided in Appendix "C," page 141.

Factor analysis is a method which researchers use to analyze all the correlations obtained among all tests or ratings obtained for a sample of individuals to ascertain what the smallest number of more basic, underlying, common factors may be. It is possible, then, that the 50 variables covered by the Welfare-Rehabilitation Project's Diagnostic Evaluation Format might really reflect only 12, 20, or 25 more basic factors having diagnostic, or predictive, value in rehabilitation work. Manifestly, it would be more convenient and practical to assess a few basic diagnostic characteristics than to measure and rate 50 of them or more. At the same time, if some one or another of the original ratings or measures were to be deemed clinically crucial, it should not, obviously, be thrown out in favor of a factor-variable.

Factor Analytic Results for DEF Variables

Factor analytic examinations of several subsets of the variables covered by the Diagnostic Evaluation Form for the first 113 clients dealt with by the Project have been made. They will be presented and commented upon in subsets at this point. (Tables are in Appendix C)

Psychological and Social Variables. Correlation coefficients were calculated among 13 DEF variables reflecting verbal, numerical and general academic abilities; intellectual functioning; perception; dexterity;

projective ratings of adjustment; aspiration level; and attitudes toward family, government, training, education of children, and affection. These correlation coefficients, when factor-analyzed, yielded evidence of only four basic factors, namely:

Factor I:	General Academic Ability
Factor II:	Dexterity, and Intellectual Function
Factor III:	Positive vs. Negative Adjustment to Self, Family, and Government
Factor IV:	Positive vs. Negative Attitudes Regarding Training Child Education, and Affection

These four factors could probably be adequately measured by (1) the numerical ability rating; (2) the rating of intellectual functioning or dexterity; (3) the projective assessment; and (4) either the attitude toward training or the affection rating of the DEF.

Family Management, Family Health, and Appearance Ratings. A factor analysis of the correlation coefficients obtained among 10 DEF variables in the above named categories of ratings yielded two major underlying factors:

Factor I:	Good vs. Poor Management and Sanitation
Factor II:	Wholesomeness (or Healthy, Attractive vs. Unhealthy, Unattractive Appearance)

It is our tentative conclusion that two DEF rating variables probably can fairly represent these two factors with no real loss in adequacy of information.

These variables are:

Factor I:	Time Management Rating
Factor II:	Personal Hygiene Rating

Factor Analysis of Medical Examination Ratings Correlation coefficients among 10 medical examination ratings of DEF physical status variables were computed and factor analyzed. The system ratings correlated and factored were:

1. oral hygiene

2. muscle

3. bone

4. respiratory

5. cardio-vascular

6. gastrointestinal and genitourinary

7. endocrine and weight

8. neurological

9. sight

10. hearing

Four major factors accounted for only about 2/3 of the total variation on these scales among the clients in the Project's male sample only, hence it must be presumed that a substantial portion of variation among clients in physical attributes cannot be accounted for by the four factors obtained. There is probably substantial clinical value to rating all ten variables separately. However, if one were merely seeking an economical set of physical variables to rate, it would be worth retaining only those which best define the four factors obtained. Though concerned with ten seemingly quite separate characteristics of physical status, the attributes rated clearly showed patterned correlations (factors) among themselves. For example, ratings of hearing were significantly though not highly associated with ratings of all other systems except those of gastrointestinal and genitourinary systems. The ratings of the GI and GU systems were independent of the ratings of all other systems. Our factor analysis indicated that a minimum, somewhat valid and economical assessment of an adult male's physical condition should pay most careful attention to examining and rating:

I. Cardiovascular condition

II. Neurological status

III. Respiratory system

IV. The Gastrointestinal and Genitourinary systems

Part Summary: Predictor Variables in the DEF. Having outlined the factor-analytic results in a none too technical manner, the findings can be summarized by attempting to answer the question with which we began. In essence, that question involved two more specific questions.

1. Which DEF ratings and measures would probably constitute a barely minimum "diagnostic battery?"

2. Which DEF ratings and measures are needed in analytic studies aimed at predicting criteria of client "success" in rehabilitation?

From the results obtained, it was early recommended that virtually all of the DEF variables should continue to be rated or measured until completion of the Project's criterion prediction studies, since such variables might turn out to be relatively valuable predictors of such criteria. Indeed, the diagnostic effectiveness of each DEF variable can only be judged adequately in terms of its utility for criterion prediction, a matter to be reported on in a later Section of this document.

What are the Major Predictor Factor-Variables Assessed by the Work Attitudes Scales for These Clients?

Regardless of differences in their jargons, most contemporary psychological theorists (see, e.g., Lindzey, 1958) hold that much of the variance in behavior among human beings probably grows out of individual differences in attitudes, motivations, and ways of construing reality. Therefore, the degree to which a welfare client may achieve rehabilitation (in a vocational sense) may be related to his attitudes toward work, self, potential coworkers, bosses, and others.

In the present demonstration-research endeavor, an attempt was made to obtain a systematic appraisal of each client's attitudes, motives, etc. by having him respond to each of the 250 self-report items in an instrument called the Work Attitudes Scales (WAS). The WAS was originally devised for vocational counseling use under copyright apart from the present Project by Beck, Rast, and Lorenzo. It existed in parallel English and Spanish versions, and could be administered in groups to clients who could read or by an interviewer to those who could not read. Thus, the WAS appeared well-adapted for use in the present Demonstration-Research Project.

An account of our factor analyses of the WAS appears in Appendix C. The two factors shown in Table 4 were found to underlie the correlations among the original 13 WAS scales. Provisionally, the two factors identified in Table 4 have been named as follows:

Factor I: Favorable Attitudes toward Self, Others, and Work

Factor II: Autonomy and Ambition

Furthermore, taking into account both the "factor loadings" shown in Table 4 and the scale reliability coefficients shown in Table 5, it appears that only those scales which loaded Factor I in this analysis are, at present, reliable enough for use clinically or in research. The best of these scales are those numbered 3 and 7, respectively. It seems likely, however, that certain of the scales which appeared on Factor II might be important enough to be worth lengthening substantially in order to increase their reliability. Scales 2, 8, and 13 would seem especially worthy of such revision.

TABLE 4

VARIMAX ROTATED (ORTHOGONAL) FACTORS AND FACTOR LOADINGS (ABOVE .45) FOR 13 JUDGMENTALLY DERIVED WAS SCALES (N = 103)

Construct Variable or Scale No.	Factors and Factor Loadings* I Favorable Attitude Toward Self, Others, & Work	II Autonomy and Ambition
1. Commitment to Work	.73	—
2. Good vs. Poor Work Habits	—	.60
3. Good vs. Poor Attitudes Toward Employers	.88	—
4. Good vs. Poor Interpersonal Attitudes	.58	—
5. Hopefulness vs. Hopelessness	.65	—
6. Favorable vs. Unfavorable Self-Concept	.68	—
7. Good vs. Poor Self-Adjustment	.81	—
8. Autonomous vs. Dependent Attitude	—	.60
9. Flexible vs. Rigid Orientation	.77	—
10. Favorable Family Attitude to Work	—	.58
11. Dependence on vs. Independence from Government & Welfare Support	-.54	—
12. Lack vs. Holding of Special Prejudices	.46	—
13. Ambition vs. Lack of Ambition	—	.64
% Total Variance measured by Factor	34.95	15.91

* Factor loadings less than .45 omitted.

TABLE 5

POSSIBLE RAW SCORE RANGES, MEANS, STANDARD DEVIATIONS, AND SPLIT-HALF SPEARMAN-BROWN REHABILITIES FOR 13 JUDGMENTALLY DERIVED SCALES

(N = 103)

Construct Scale	Possible Range	Mean	SD	r_{tt}
1	0-15	6.61	2.16	.25
2	0- 5	2.75	1.13	.23
** 3	0-22	11.42	4.56	.80
** 4	0-11	6.61	2.08	.67
* 5	0-11	5.76	1.81	.40
** 6	0-12	6.84	2.35	.65
** 7	0-12	4.58	3.00	.75
8	0- 5	2.31	1.12	.08
* 9	0- 5	3.17	1.35	.40
10	0- 7	2.53	1.64	.62
** 12	0- 4	1.41	1.14	.60
13	0- 6	3.33	1.06	.15

Section Summary

This section of the present report has presented results in the first phase research of the present Project. These results were chiefly descriptive in character. By and large, they showed (1) that the Project's clientele was not altogether representative of the Welfare Department's rolls; and (2) that meaningful medical, psychological, social, academic, and other factors were indeed being measured by the Project's Diagnostic Evaluation Format (or Profile) battery. It was not recommended on the basis of Phase I results, that any variable then being assessed should be deleted from the battery.

SECTION 11

The Second Phase of The Research: Criterion Prediction Studies

The work just reviewed in this report has dealt mainly with analyses performed in order to put the Project in a position to take the research steps which were needed in order to realize its most important and specific research objectives more fully. These aims were reviewed earlier. The first phase of the research showed that a simplified, economical, systematic identification and diagnostic battery of client assessment methods might well emerge from this Project.

It is important to bear in mind that the reduction of a battery of individual assessment devices is not a matter which is properly to be done soley on the basis of factor analytic studies. Indeed, the only legitimate basis for judging which assessment instruments and methods should, in the long run, be retained lies in the empirical demonstration that some, more than others, are efficient forecasters of relative degrees of the "success vs. failure" of individuals in becoming "vocationally rehabilitated." When the "forecasting efficiency" of each device or appraisal is known in terms of "payoff criteria"—by itself and in concert with others— it may be possible to reduce the assessment battery to a short, effective "factor-representative" and "criterion predicting" set of instruments.

The Criterion Problem

Social scientists have always had great difficulty in selecting and/or developing suitable and practically usable criteria of the important individual and social changes which they attempt to bring about by action programs. Yet there is no point to social evaluation research unless criterion measures each of which has at least some reliability, validity, and relevance can be obtained.

In the present Project, the central aims of social action were to enable people to work; to help them gain work in suitable occupations; to help them stay working; and, thus, to get them off the Welfare Department's rolls; to improve family life; to increase individual independence and self-respect; and to reduce poverty and social blight. The Project has sought to show how to do these things more effectively and to study the kinds of people with whom they may be most and least effectively accomplished. Thus, the Project was designed, explicitly or implicity, to be of value to existing social and educational agencies. To the extent that, during its life, this Project has demonstrated methods of effective intervention in the circumstances of the disabled poor, and has learned to predict who can most probably be helped, to that extent existing agencies may have been helped to improve their own activities.

The key, then, whether one seeks to know how the action program is going or wished, on the other hand, to develop ways of forecasting who are the people most susceptible to rehabilitation lies in selecting adequate criteria of rehabilitation. To select and somehow measure adequate criteria requires that the basic aims of the action program be particularized in terms of specific and observable changes ("movement") in people between their referral and acceptance into the program and the time their cases are "closed."

Criterion Data Collection Devices

It was recommended that the San Antonio Welfare-Rehabilitation Project adopt for purposes of assessing changes brought about in each of its clients:

> Data Sheet 2 - Accepted Status, a form already available for for assessing "movement" in clients of selected demonstration projects in the vocational rehabilitation of disabled public assistance clients.

It was also suggested that Data Sheet 1 - Referral - should be systematically kept for all persons referred to the Project regardless of their being or not being subsequently accepted. Both of these Data Sheets are pre-coded, thus helping in the management of the data by research analysts.

These Data Sheets—especially Data Sheet 2—focus upon changes in the situation of individual clients, changes which are both significant and fairly readily and objectively observed and appraised. The items observed range from "weekly earnings (1) at acceptance and (2) at closure" to changes in various social services provided by the public welfare agency (1) before referral, (2) during Project activity, and (3) continued." Data Sheets 1 & 2 were adopted by the San Antonio Project for its recording of criterion and other data for each client. Copies of these Data Sheets appear in Appendix A.

The Criteria

In order to derive analytically a scheme for selecting clients with maximum chances of success it is necessary to define operationally the concept of success. In the case of this Project, it would seem that any definition of success would have to consider both the client's income and the amount of public assistance he receives. Ideally, the client's earnings should increase between the dates of acceptance and closure. Conversely, the amount he receives in public assistance should be diminished in the same time interval. This, in effect, dictates that two distinct criteria of rehabilitation be used, for, in practice, changes in the magnitudes of the two types of income tend to occur fairly independently of one another. Nor is it sufficient to consider each client's final status only. To be both useful and realistic, a criterion measure must not lose sight of the client's pre-training situation with respect to earnings and relief.

In light of the above remarks it would seem that the most relevant pieces of information about a subject who has been through the program would be the difference scores implied in the preceding discussion. These are:

1. Amount of public assistance payment received by client at acceptance minus the amount of public assistance payment at closure;

2. Weekly earnings of client at closure minus weekly earnings of client at acceptance.

Fortunately the data required to compute these differences were avialable for most of the client sample. Therefore, statisticians at the Personnel Services Research Center did in fact compute these scores and employ them as criterion measures.

The Predictors

There is available for each client who successfully completed the program a considerable quantity of data, including psychological, physiological, and demographic information. With due consideration given to the possible merit of every available measurement, a slate of 97 variables was selected for further analysis. This, of course, is a much larger pool of information than one would desire to use in a clinical prediction situation. The subsequent analysis was therefore designed to select from the pool of available data a manageable composite with maximum predictive power.

It is important to note at this point that these 97 predictor variables include virtually all of the useable information available for the client sample. Furthermore, it is stressed that subjective judgements of item relevance played no part in the subsequent reductions in the size of the list. Deletions, then, were made only on the basis of a statistical evaluation of each variable's predictive efficiency.

The Method

In addressing themselves to the problem of predicting changes in client earnings and public assistance income, the statisticians at the client Personnel Services Research Center employed the technique of multiple linear regression. The basic purpose of this technique is the generation of a mathematical equation to express succinctly the optimum method to be used in predicting scores on a criterion variable from a set of one or more predictors. The general form of such an equation is:

$$Y = a_1X_1 + a_2X_2 + a_3X_3 + \ldots + a_nX_n$$

where

Y represents the criterion variable,

X_i is a predictor $(i = 1,2,3,\ldots,n)$,

n is the number of predictors in the system, and

a_i is the weight to be assigned to the i^{th} predictor variable for maximum efficiency of the entire system.

Since the criterion scores and predictor scores are available from the data, the trick, obviously, lies in the computation of a set of weights possessing maximum predictive efficiency. It is not within the scope of this report to discuss in detail the mathematical theory which dictates the manner in which the weights are computed. It will, rather, be necessary simply to assert that, for a given collection of data, the weights yielded by the multiple regression procedure are the best possible in a predictive sense. Furthermore, the predicted scores yielded by the model may be mathematically compared with the observed criterion scores in such a fashion as to yield statistics which are indicative of the equation's efficiency as a predictive device.

The careful reader will have observed that the foregoing discussion of multiple regression described (in very general terms) what is to be the end product of this phase of the research, but did not specify the analytical procedures to be used in selecting the most valuable predictor variables. There are, in fact, two different ways of going about this. One method would begin by including all 97 predictors in the system. Each would then be dropped individually and the predictive efficiency of the resulting equation noted (following calculation of new weights). In this manner it would be possible to select the predictor making the smallest contribution to the efficiency of the entire system. This variable would then be omitted and the entire process repeated with the resulting 96-predictor system. Repetition would continue until the predictor composite was reduced to some desired size. A less complicated method of arriving at the same result proceeds in precisely the opposite direction. The method starts with no predictors in the system and adds each individually, calculating its weight and noting its efficiency. Thus the best one-predictor model is identified. Subsequent iterations of this procedure may be performed until a model of desired dimensions is constructed.

Using the second method two regression equations (one employing five predictor variables, the other ten) were generated for each of the two self-support criteria. As an additional check on the validity of these models each predictor was omitted individually so that the predictive efficiency of the single variable as part of the composite could be meaningfully assessed and measured. We did, in fact, employ a test of statistical significance at this point in order to be certain that each of the final predictors truly merited inclusion in the composite.

At this point our study of the predictors indicate that some of the best predictors were "treatment" variables which are differentially applied by the staff during the course of a client's contact with the Project. Most of these variables' efficiency in prediction is explainable by the axiom that the more you do for a client the better are his chances of success. Since these treatment variables are probably best left to the discretion of the staff, we next asked the question: How effective is prediction from variables of the Diagnostic Evaluation Format (DEF)? Models were generated for predicting the criteria using only DEF variables as predictors.

The Results

In assessing the results of the procedures described above, the reader must bear in mind the fact that the final predictor sets were selected during the course of the research and were not set forth within the framework of an hypothesis. It is therefore apparent that probability values based upon the normal tests for statistical significance would not have their usual meanings. It is for this reason that we prefer to evaluate the predictive efficiency of the models in terms of the amount of criterion variance the predicted scores actually explain.

Before turning to the actual issue of prediction, however, it might be advisable to consider some interesting, but as yet unmentioned, aspects of the criteria. First, the coefficient of correlation between the two is .48. This would indicate that only about 23 per cent of the variance of either can be explained in terms of variation in the other. We would argue that this degree of independence makes the treatment of these variables as distinct entities desirable. Secondly, the means of the criterion measures present a basis for evaluating the program's impact. If the program, in general, were successful, then on the average there should have been a decrease in public assistance payment to client. Furthermore, the resulting decrease in client assistance should ideally have been compensated by increased earnings. Examination of the criterion means will show that this is indeed the case. The average client at closure drew $69.19 less in monthly public assistance than he had been drawing at acceptance. On the other hand his weekly earnings increased $32.03, or about $134 on a monthly basis. Obviously then, the Project truly is taking clients from the relief rolls and placing them in gainful employment.

Tables, 6, 7, 8, 9, 10, 11 present the information needed to use the

TABLE 6

Model 1: Prediction of Decrease in Public Assistance
Ten Predictors

$R = .8130 \quad R^2 = .6609$

Weight	Predictor
-5.14	Sum of Codes for Health Care
-4.99	Sum of Codes for Improved Financial Functioning
45.02	Sex: 1=Male; 0=Female
21.85	1 if White-Mexican Extraction (Latin American); 0 otherwise
-68.87	1 if Felony; 0 otherwise
-20.11	1 if Steady Work History up to Immediate Past; 0 otherwise
-1.11	Age at Time of Referral
-4.41	Respiratory
10.30	Intellectual Functioning
0.72	WAS Factor Scale I
33.02	Regression Constant

TABLE 7

Model 2: Prediction of Increase in Weekly Earnings Ten Predictors

$R = .8472 \quad R^2 = .7178$

Weight	Predictor
12.38	Number VR Interviews During Referral Status with Ohter Placement Resources
-3.18	Sum of Codes for Educational or Vocational Training
1.82	Sum of Codes for Improved Family Functioning
3.66	Number of Interviews, Employer(s)
.04	Training and Training Materials (cost)
20.53	1 if Steady Work History up to Immediate Past; 0 otherwise
-11.56	1 if Spotty Work Record; 0 otherwise
28.51	1 if Had Extensive Vocational Training; 0 otherwise
-.67	Age at Time of Referral
-1.71	WAS Factor Scale II
64.67	Regression Constant

TABLE 8

Model 3: Prediction of Decrease in Public Assistance
Five Predictors

R= .7235 R^2= .5235

Weight	Predictor
-5.86	Sum of Codes for Health Care
46.47	Sex: 1=Male; 0=Female
-1.40	Age at Time of Referral
-3.74	Respiratory
10.05	Intellectual Functioning
71.39	Regression Constant

TABLE 9

Model 4: Prediction of Increase in Weekly Earnings Five Predictors

$R = .7683 \quad R^2 = .5902$

Weight	Predictor
3.76	Number of Interviews, Employer(s)
.05	Training and Training Materials (cost)
26.14	1 if Steady Work History up to Immediate Past; 0 otherwise
33.16	1 if Had Extensive Vocational Training; 0 otherwise
-.59	Age at Time of Referral
33.26	Regression Constant

TABLE 10

Model 5: Prediction of Decrease in Public Assistance From Diagnostic Evaluation Formal Variables

$R = .7728 \quad R^2 = .5972$

Weight	Predictor
57.78	Sex: 1 = Male; 0 = Female
-78.63	1 if Felony; 0 otherwise
-32.69	1 if Steady work history up to immediate past; 0 otherwise
2.58	Years in school
-6.51	Respiratory
8.51	Intellectual Functioning
4.06	Perception
.70	WAS Factor Scale I
-35.34	Regression Constant

TABLE 11

Model 6: Prediction of Increase in Weekly Earnings from Diagnostic Evaluation Format Variables

$R = .6824 \quad R^2 = .4656$

Weight	Predictor
14.80	1 if Steady work history up to immediate past; 0 otherwise
29.84	1 if had Extensive Vocational training; 0 otherwise
-1.08	Age at referral
-2.54	Respiratory
3.92	Intellectual Functioning
-2.49	Projective
76.03	Regression Constant

prediction equations derived in this study. In order to predict an individual's score on one of the criterion measures, one simply multiplies each predictor score by its corresponding weight and sums across predictors, adding the regression constant to the total. The resulting figure is the individual's predicted criterion score.

For example, suppose we want to predict the increase in weekly earnings of a particular subject who has proceeded in the program through the Diagnostic Evaluation Format (DEF) stage:

DEF Scores	Variable Description	Applicable Weight	Product
0	1 If steady work history up to immediate past; 0 otherwise	14.80	0
0	1 If had extensive vocational	29.84	0
33	Age at referral	-1.08	-35.64
3	Respiratory	-2.54	- 7.62
5	Intellectual functioning	3.92	19.60
9	Projective	-2.49	-22.41
	Regression Constant	76.03	76.03
	Predicted Increase in Weekly Earnings		$29.96

More important from the researcher's point of view, however, are the multiple correlation coefficients presented in the tables mentioned above. Without exception, these coefficients indicate an extremely high degree of relationship between criterion and predictor composite. The percentage of criterion variance which can be explained by variation in the predictors ranges from 52.4 to 71.8. It is our contention that these measures indicate relationships too strong to be artificial. We would conclude, therefore, that support and income differences are predictable.

The conclusion that the extent of a client's movement toward self-support is predictable does not guarantee perfection in the prediction model. As a check on the efficiency of the individual predictors within the system each was tested statistically to evaluate its contribution to the composite. A test of statistical significance (Tables are found in Appendix C) was conducted for each predictor variable to yield the probability of chance occurrence of a contribution as large as its own. The fact that the traditional level ($P<.05$) of significance was attained in nearly all cases is not really very surprising, for the entire analytic procedure was designed to include only the best of the available predictors. Nevertheless, the information is not without import. The fact that the ninth and tenth predictors incorporated in the composite in some cases are indeed making significant contributions to the power of the equation indicates that paring the lists of predictor variables to less than ten would result in a real loss in efficiency. The other aspect of the dilemma - that making additions to the system would markedly increase predictive capability - is likewise emphasized by these tests. It should be obvious, however, that at some point one must draw the line which attempts to define the ideal position on the accuracy-convenience continuum.

Lest we seem overly optimistic about the results of the regression analysis, it would probably be wise to add a few words of caution at this point. It was stated earlier that the weights generated by the multiple regression technique were the best possible for the data under consideration. This does not guarantee that these weights would yield equally good prediction with a different sample. Especially is this true with respect to the present study, for the sample of clients upon whom data was available on all variables numbered only 64. Furthermore it was shown earlier that the clients served by the Project differ markedly in many respects from the total population of active welfare recipients. This would probably lead to difficulties if an attempt were made to apply the prediction equations to a client sample which more closely resembled the parent population.

The cure for most of these ills is cross-validation of the regression equations with a different sample of clients. This would permit refinement of the prediction equations as well as providing a test of their efficiency in practical application.

Other Analyses

It should be pointed out that the regression analysis which has been described in the preceding text was applied only to those clients who completed the entire process. In analyzing the input to the program, however, there are actually three distinct categories to be considered. These are:

1. Those clients who completed the program;
2. Clients who were referred to the program and enrolled in it, but subsequently discontinued before completion;
3. Individuals who were referred to the program but were not accepted.

The reason for seeking possible differences among these groups (especially groups 1 and 2 are obvious. There can be no question of the desirability of being able to forecast, in advance, which of the potential clients would be likely to complete the entire process.

Before discussing the statistical techniques which were actually employed in evaluating the observed differences, it would be wise to point out that there were two fundamentally different types of data available for analysis. Continuous data, such as income, years of schooling, age, etc., form one general classification. Categorical data (e.g. sex, ethnicity) are an entirely different sort of thing and require different treatment. Statistical techniques involving the computation of means, for example, would be inappropriate if applied to nominal (categorical) data.

To take advantage of the full power of continous data, the technique of analysis of variance was used where such data was available. Analysis of variance is an inferential technique used to assess the strength of a relationship between a continous variable and a nominal variable (in this context the three-category breakdown mentioned above). Means are computed for each category of the nominal variable and the dispersion of individual cases around these means is expressed mathematically. When the scores of all the individuals falling into a group tend to cluster tightly around the group mean, but the means themselves are widely separated then there are likely to be real differences among the groups. The question, then is whether the variation among the categories is greater than the dispersion within them. The relative magnitudes of the among-groups and within-groups variation are weighed by the analysis of variance technique which forms a statistic known as the F-ratio, the size of which is indicative of the degree of relationship between the variables under consideration.

Where the data exist in nominal form, the Chi-square technique was employed. Chi-square provides a means of expressing mathematically the extent to which the distribution of cases within the cells of a cross-classification table depart from what one would expect from an examination of the marginal distributions of each variable. When the discrepancy between the observed and expected distributions is considerable, indicating a high degree of relationship, the fact is reflected in a high value of Chi-square (the name given both to the technique and the statistic which it generates).

Both Chi-square values and F-ratios can be tested for statistical significance. The probability value associated with such tests is the probability that the observed association would have occurred by chance when sampling from a population where no relationships did in fact exist.

The results of the analyses of variance are to be found in Table 12, while the Chi-square results are presented in Table 13.

Significant results were detected with respect to:

Amount of Monthly Welfare
Length of Time on Welfare
Oral Hygiene
Muscle
Bone
Respiratory
Cardio Vascular
GI & GU Systems
Endocrine & Weight
Neuro
Sight
Hearing
Perception
Dexterity
Projective
Attitude Toward Family
Attitude Toward Govt.

Table 12
Single Classification Analyses Variance

	Group 1 Mean *	Group 2 Mean *	Group 3 Mean *	Among Groups M.S.	Within Groups M.S.	df 1	df 2	F	P
Years In School	5.56	4.75	5.61	8.98	17.37	2	157	0.517	.6030
Number of Dependents	4.80	6.06	4.61	24.22	11.21	2	157	2.161	.1165
Amount Monthly Welfare	81.36	82.38	63.53	6347.54	1840.10	2	157	3.450	.0331
Length of Time On Welfare	35.66	26.47	20.31	3796.29	1112.94	2	157	3.411	.0344
Age in Years	37.70	39.81	39.28	62.16	106.80	2	157	.582	.5652
Age at time of referral	37.77	36.72	39.83	78.94	112.58	2	157	.701	.5020
Personal Hygiene	5.81	6.28	5.81	2.81	3.68	2	157	.764	.5283
Clothing	5.60	6.17	5.83	3.22	3.97	2	157	.811	.5500
Aesthetic	5.02	5.06	4.75	1.54	3.34	2	157	.476	.6281
Oral Hygiene	8.14	8.13	6.28	66.01	6.50	2	157	10.159	.0002
Muscle	8.09	7.97	6.23	63.60	8.39	2	157	7.577	.0011
Bone	7.48	7.91	6.20	40.72	9.64	2	157	4.225	.0160
Respiratory	7.16	8.16	6.38	34.52	9.30	2	157	3.713	.0258
Cardio Vascular	8.27	8.22	6.45	62.02	8.43	2	157	7.355	.0012
GI & GU System	8.20	7.91	6.48	51.32	9.75	2	157	5.262	.0064
Endocrine & Weight	8.20	8.94	6.89	52.32	7.24	2	157	7.227	.0014
Neuro	7.70	8.03	6.13	55.82	10.51	2	157	5.314	.0061
Sight	8.22	8.69	6.70	56.01	7.33	2	157	7.639	.0010
Hearing	5.58	5.16	2.83	132.63	5.27	2	157	25.180	.0000**
Perception	7.38	6.16	3.16	294.92	9.93	2	157	29.687	.0000**
Dexterity	4.67	4.09	2.19	104.40	9.20	2	157	11.346	.0001
Projective	5.03	3.84	2.00	148.39	5.25	2	157	28.269	.0000**
Attitude Toward Family	6.81	6.25	5.53	26.34	5.17	2	157	5.096	.0074
Attitude Toward Govt.	5.61	5.16	4.42	22.82	4.10	2	157	5.570	.0049
Attitude Toward Trng.	6.84	6.22	5.59	25.00	6.65	2	157	3.762	.0246
Attitude Toward Child Education	5.55	4.78	4.05	36.00	8.77	2	157	4.107	.0179
Family Affection	6.05	4.41	3.77	86.47	9.31	2	157	9.285	.0003
Management of Money & Equivalent	5.13	4.56	9.67	21.39	.97	2	157	2.685	.0695

	Group 1 Mean *	Group 2 Mean *	Group 3 Mean *	Among Group M.S.	Within Groups M.S.	df 1	df 2	F	P
Management of Time	5.16	4.22	3.72	33.68	7.44	2	157	4.523	.0122
Management of Recreational Resources	3.89	3.22	2.72	22.07	5.33	2	157	4.141	.0173
Individual Hygiene	5.39	4.78	4.09	26.93	8.37	2	157	3.217	.0414
Extent of Family Illness	5.70	5.03	4.33	30.25	8.65	2	157	3.496	.0317
Age at Referral	36.41	37.84	35.16	82.01	188.39	2	173	.435	.6536
Highest Grade in School Completed	5.60	4.56	4.81	17.21	12.37	2	173	1.391	.2504
No. of Months From Client's Most Recent Opening for PA to Referral	11.66	10.03	7.89	252.95	309.93	2	173	.816	.5525
No. of Years Since Last Employed Full-Time	2.46	2.37	2.36	.21	1.61	2	173	.132	.8767
No. of VR interviews during referral status with Client	3.40	3.75	3.47	1.42	5.80	2	173	.245	.7862
No. VR interviews with Family	1.31	1.41	.13	30.13	16.42	2	173	1.835	.1606
No. VR Interviews with Employer	2.71	2.31	.56	86.22	95.53	2	173	.903	.5899
No. VR Interviews with Others	.29	.44	.11	1.25	.77	2	173	1.634	.1962
Rehabilitation	51.63	81.38	83.73	21465.75	2745.98	2	173	7.817	.0009
By workshop	1.20	2.56	.63	40.15	85.81	2	173	.468	.6330
Other Sources	26.66	27.03	36.78	2043.38	858.31	2	173	2.381	.0934

* Groups are those defined on Page 51 of text.

** $P < .00005$

TABLE 13

Summary of Chi-square Computations*

Sex

	Group 1	Group 2	Group 3
Male	51	25	37
Female	13	7	27

Chi-square = 8.4654 df = 2 P = .0146

Ethnicity

	Group 1	Group 2	Group 3
White-Anglo	5	3	9
White-Mexican (Latin American)	57	22	42
Mixture of Anglo, Mexican	0	1	2
Negro	1	6	10

Chi-square = 14.2506 df = 6 P = .0274

Religion, Participation

	Group 1	Group 2	Group 3
Catholic, constant	11	5	8
Catholic, occasional	32	11	17
Catholic, never	1	5	10
Protestant, constant	1	1	2
Protestant, occasional	6	4	6
Protestant, never	1	1	1

Chi-square = 12.8159 df = 10 P = .2352

Housing

	Group 1	Group 2	Group 3
Good housing, good neighborhood	3	2	3
Good housing, poor neighborhood	6	3	3
Poor housing, good neighborhood	2	1	4
Poor housing, poor neighborhood	17	10	14
Public housing	14	5	9

Chi-square = 2.8714 df = 8 P = .9416

Primary Language

	Group 1	Group 2	Group 3
English only	5	8	17
English primary, Spanish secondary	7	1	1
Spanish primary, English secondary	41	22	40
Spanish only	9	1	5

Chi-square = 15.4410 df = 6 P = .0176

Marital Status

	Group 1	Group 2	Group 3
Married	45	24	34
Separated	4	3	11
Divorced	7	2	6
Common law marriage	0	1	1
Widow or widower	1	0	1
Unmarried	1	1	3

Chi-square = 9.2372 df = 10 P = .5108

Police Record

	Group 1	Group 2	Group 3
None	43	22	35
Misdeameanor	12	5	9
Felony	1	0	1

Chi-square = 0.6968 df = 4 P = .9494

References

	Group 1	Group 2	Group 3
Appropriate response	20	9	22
Limited response	34	15	20
Inappropriate response	2	3	8

Chi-square = 8.8238 df = 4 P = .0849

Work History

	Group 1	Group 2	Group 3
Steady work history to immeiate past	16	6	11
Steady work history in distant past	15	8	11
Spotty work record	30	13	28
No work record	1	2	4

Chi-square = 3.4139 df = 6 P = .7573

Previous Vocational Training

	Group 1	Group 2	Group 3
Extensive training	4	1	1
Some training	4	4	6
No previous training	52	26	50

Chi-square = 3.3210 df = 4 P = .5732

Previous Voc. Rehab. Experiences

	Group 1	Group 2	Group 3
Prosthetic training services	3	0	0
Physical restoration only	3	0	1
Training and placement	3	2	2
No previous VR experience	54	30	57

Chi-square = 7.2954 df = 6 P = .2946

Telephone Service

	Group 1	Group 2	Group 3
Yes	17	2	16
No	45	25	46

Chi-square = 0.3418 df = 2 P = 8440

* Groups are those defined on Page / of text.

Attitude Toward Child Education
Family Affection
Management of Time
Management of Recreational Resources
Individual Hygiene
Extend of Family Illness
Rehabilitation
Sex
Ethnicity
Primary Language

The same sort of procedures were followed in order to analyze the differences between groups:

1. Those clients who completed the program, and

2. Clients who were referred to the program and enrolled in it, but subsequently discontinued before completion.

Significant differences were found between the two groups on the following variables:

	Mean Group (1)	Mean Group (2)
Race or Ethnicity		
Primary Language		
Endocrine and Weight	8.20	8.94
Numerical Aptitude	5.02	3.56
Verbal Aptitude	5.19	3.84
Perception	7.38	6.16
Projective	5.03	3.84
Family Affection	6.05	4.41

It is possible to develop formulas for prediction of group membership just as formulas have been developed for prediction of changes in Public Assistance and Weekly Earnings, but development of such is to await a larger sample.

Section Summary

This section of the present report has described the selection of criteria:

1. Decrease in public assistance.

2. Increase in weekly earnings.

It has explored the extent to which these criteria are predictable from Diagnostic Evaluation Format variables and differential treatment variables. In all cases the predictions are very good and highly signifisant statistically, based on this population. Differences in group membership, were explored statistically where the groups are defined as:

1. Those clients who completed the program.

2. Clients who were referred to the program and enrolled in it, but subsequently discontinued before completion.

3. Individuals who were referred to the program but were not accepted.

Many statistically significant differences between the groups were found on various measured attributes.

Chapter IV

DEMONSTRATION AND RESEARCH RESULTS

SECTION 12

DEMONSTRATION RESULTS

Synopsis

Operational results for the 29-month period were very gratifying. During the first five months, February to June, 1964, seventy clients were entered into Project prevocational activity and moved out into job training assignments as appropriate. In this initial period no closures of any kind were made (from referral or otherwise). A summary over the period of the next twelve months shows 79 cases were closed (including those closed from referral) and 30 of these were closed in successful employment. Two counselors and two caseworkers had actually worked with a total of 165 clients during the period, and at the end 86 were left on the rolls in some stage of the rehabilitation process. During the final twelve-month period ending June, 1966, a total of 102 cases were closed of which 38 were successful. During this same period, the staff had worked with a total of 209 clients, and at the end 107 were still in the process. It is interesting to note that the success ratio was almost indentical for each of the two twelve-month periods with an overall rehabilitation success rate of 38 percent.

This rate was based on 68 success cases from a total of 181 closures. Special significance may be attached to the fact that random sampling was attempted and the 181 closures included closures from referral. If only cases accepted for full services were considered, the success rate would be 70 percent. (See Table 28, Appendix C.)

The cooperative plan and research design worked so well that no significant changes were required during the course of the report period. The Project staff applied specialized knowledge, used resources, and cooperated in a team approach to client centered goals. The spin-off results in valuable research information were enhanced by the ability of team members to identify with Project objectives while retaining and improving professional identity.

In the final analysis, operation features which seemed to give better than average rehabilitation facility for AFDC recipients include (1) timing or readiness for rehabilitation; (2) intensive case services; (3) the team approach; and (4) prevocational evaluation-adjustment activity. These and other important aspects of operation will be discussed in considerable detail. Initially, the evolvement of an adequate referral system should receive attention because of its importance in overall program effectiveness.

The Referral System

An effective referral system is a prerequisite to any smoothly functioning public service facility. While there are many general referral systems, there is no knowledge of a system tailored to the needs of this Project. One of the Project objectives was..." to establish a systematic means of identifying AFDC applicants or recipients who are potential candidates for rehabilitation." Inasmuch as another objective was to "have a research aspect of the Project..." the research design prescribed a minimum of referral criteria to approximate random sampling during the period of research data gathering. Several systems were evolved, each with improvements to carry out the design features. Finally, as research drew to a close, the way was cleared to apply referral experience and related research indications. Plans were initiated by responsible SDPW representatives for completely systematizing referrals.

Referrals during the period, February, 1964, to about October, 1965, were made by the regular caseworkers, with little resemblance of an established or consistent referral program. Irregular intake, as a result, caused periods of work overload and other periods of slack. Adverse effects in prevocational classes were experienced from inability to maintain a reasonable number in attendance. Because of problems of this nature, the need was recognized for a review of referral procedure and related activities.

A study was made by the Associate Project Director, SDPW, to define problem circumstances and look for solutions. It appeared that many Project procedures and functions hinged on one another so that a weakness in one lessened fruitfulness of adjoining activities. Some areas of concern were:

1. Input depended on output (caselaad limitation).
2. Output was evaluated by regular staff reviews.
3. Staff review (logically the place to survey movement bottlenecks) Some considerations were:
    a. Hesitation in screening out cases where disabling conditions made vocational rehabilitation unlikely for a significantly long time.
    b. Malingering of client
    c. Insoluble social problem expected to extend over a significantly long period.

Special attention to case movement by the Project staff resulted in identifying a number of cases where favorable progress was unlikely for six months or more. In such cases it seemed logical to consider screening out those clients where specialized services were not expected to produce constructive results within that period. In this way others were provided an opportunity to be served and re-referral of screen-outs could be made at a later and more appropriate time if indicated. A letter from the counselor and caseworker was inserted in the SDPW folder for each client screened out to describe the reasons for the action.

In addition to the need for recognizing output bottlenecks to increase input capability, certain parts of the input problem seemed to stem from the referral itself. Due to personnel turnover, transfer, etc. among regular caseworkers, knowledge of exact Project function and referral procedure was discovered to be very vague. With the approval of the Director and Assistant Director of the SDPW Regional Office, the Associate Project Director, SDPW, organized an indoctrination program for AFDC supervisors and their units.

The regular AFDC staff orientation program was conducted by periodically inviting one, or sometimes two, units at a time to come in for a first hand look at Project operation. An orientation schedule was established and periods of four to six hours were planned with each group. All Project counselors and caseworkers participated in the orientation training and helped to define clearly the role each played in the rehabilitation process. The regular AFDC caseworker was helped to see that he or she played an important part in making timely and proper referrals.

The indoctrination program included presentation of information, large charts, 35mm slides of various activities, discussion and sampling of actual operations. The Prevocational Evaluation-adjustment Center was visited and referring caseworkers were able to see some of their previously inhibited referrals participating in group activity. The information was enthusiastically received and the referral picture changed. An adequate backlog of referrals was accumulated; the screening criteria (research design) was well applied; and the referral input was much smoother. Another noticeable improvement was in the readiness of clients for vocational rehabilitation. This was noticeable in terms of client familiarization of opportunity and ability to participate very soon without long delay in service.

Selectivity of referrals was not representative of the AFDC population as shown by the Research Consultant's preliminary study. However, it is understandable that without more specific selection controls (avoided for research), help for male dependency may receive more emphasis in our society if a difference is observed. Also, female selection is contingent on resolving the child-care problem adequately, and for this reason, more work may be required before referral of a female.

The developmental approach in accomplishing the research requirements for referral set the stage for developing an operationally based system of referral. The model for this includes the following provisions:

1. Indoctrination as needed to provide caseworkers with information on resources, opportunities, and their role in the Project.

2. Effective selection criteria for analysis of the case and recommended (time) priority, i.e., immediate, two-four months, four-six months...etc.

3. Review of possible referrals by Project Director and Associate Director to establish a schedule of input, and counselor-caseworker assignment.

4. Family review by caseworker and introduction of client to counselor team member.

Case Services

Results of cooperative services beyond the referral stage in the cooperative plan (chart 1) may be discussed in terms of three additional stages or phases of activity. These are the diagnostic, planning, and post plan phases of case services. Certain activities within these phases appear to have special significance and will be discussed separately to give more detail.

The diagnostic phase of case services required about two to three months. The average two-month period of time devoted to prevocational classes was sufficient in most cases to complete other diagnostic work. In addition to comprehensive evaluation, it was apparent that all were benefiting from prevocational activity. This was most observable in clients' change in grooming and general attitude. Additional class time was allowed in cases where the benefits to be derived made a significant difference in clients' ability to take advantage of opportunity.

In some cases delay in concluding the diagnostic phase was due to high absenteeism in prevocational classes, requiring extension of time. A good attendance record appeared to be more related to interest and reliability than to good health as might be expected. Some of the very ill and physically disabled people were actually most reliable in attendance. On the other hand, some physically and mentally better qualified candidates for work showed their dependency inclination, illness, multitude of problems, or some of all of these by sporadic attendance or by discontinuing altogether. Every effort was made by the team members to encourage the client to attend regularly. Counseling and extensions in time were given as well as special effort on the part of the caseworker to help resolve family problems in an all-out effort to keep the client under the influence of adjustment therapy. In some cases this "hide and seek" activity continued for several months. As a last resort, uncooperative cases were screened out of the Project.

"Flare-up" of illnesses and subsequent treatment at the local charity hospital were not infrequent occurrences. In some cases clients were screened out on the basis of inability to participate because of progression of disease or frequency of illness. A general rule of thumb developed. The client was screened out if no movement could be anticipated for a period of six months or more.

Another cause of delay in a small percentage of cases was the waiting for reports of special medical examinations. Infrequently the need for additional specialist information was discovered toward the middle or latter part of the diagnostic period causing the decision on eligibility and the first staff review to be delayed. In other cases if the physician happened to be particularily busy, inquiries were necessary as a (diplomatic) reminder that the special report was needed.

After diagnostic evaluation, eligibility (based on the constellation concept) was established in a very high percentage of cases. About nine out of ten had at least one codable medical disability with other factors adding to his or her constellation of disabilities. The much higher rate of screen-out from referral (Table 28) indicates that other reasons were involved in most cases.

The planning phase of case service commenced with acceptance of the client for full services and terminated with a comprehensive social-vocational plan of rehabilitation. Early in this phase, caseworker follow-up made comparison in living pattern possible from previous visits, family counseling and from influence of prevocational classes. Favorable changes were in evidence in most cases with some extremely gratifying improvements. Living improvement and family support of the breadwinner's vocational activity were inseparable goals to be achieved. Through information feedback from prevocational classes and close counselor-caseworker team effort, many problems were pin pointed early. At this point, the preliminary plan formulated after the first home visit was easily revised, as necessary, and put into effect.

Information for establishing a vocational rehabilitation plan in the Project setting was very adequate, in spite of the many and varied personal and environmental undercurrents affecting this clientele. In addition to routine diagnostic information normally available to a DVR counselor, the Project counselor had a wealth of additional information. The systematic review of daily reports from the prevocational class instructor concerning progress, observable habits, significant comments, and the ability to appear in the prevocational class on time and regularly was extremely helpful. Detailed knowledge of class experience, coordination and review of case information by team members helped one to understand the client's personal attributes not otherwise obtainable.

The general consensus of opinion among Project staff was that most if not all social-vocational plans must be conceived and carried out with the knowledge that some degree of emotional instability would be an ever-present threat to routine completion. This is supported clinically by results of projective testing (Table 12) where the rating of six or below on the Rorschach was considered empirically significant.

It became apparent early in Project activities that careful planning was needed for the San Antonio AFDC clientele and that the necessary resources were not readily available in sufficient quantity in this community. Caseworkers were confronted with the child-care problem and spent much time in trying to help female clients arrange child care for the period of prevocational classes and subsequent job training. Prior to the time earnings could be expected to pay for child-care services, family funds were stretched thin unless a friend or relative offered to help. Usually if child care was available during prevocational classes, it was also available during job training. The public assistance grant or VR maintenance for training-related expenses did not provide funds for child-care services. It is commendable for the client to develop her own resources as far as possible, but the special cases have given rise to thoughts of securing community support for necessary child care.

Another special need consisted of more vocational outlets for multi-handicapped people. Many of the people worked with would be considered poor risks (unfeasible) without the capabilities inherent in the Project setting, or in organizations similar to Goodwill Industries, Inc. The average level of functional education (less than claimed in most cases) was a significant handicap for activity requiring educationally based mental job application. In some cases, particularly male, the physical handicaps were so pronounced that manual job applications were extremely limited. The only hope in these cases was to work out some combination of functional job performance which would be salable after on-the-job training and selective placement.

In order to plan and help improve the outlook for the multihandicapped, special training programs were established where possible. Through the help of Goodwill Industries, a commercial seamstress training program was started early in 1966. The first class of eight graduates merited a local news release at the time of their graduation.

A manufacturer and wholesaler of plaster statuary products agreed to train clients for home production and to purchase the production for resale. Although some headway has been made in enlarging the field of opportunity, the efforts are feeble compared to the needs. Most opportunities must be ferreted out piecemeal by counselor and client in close cooperation.

Results of the post-plan phase of case services for implementing, and monitoring plans, and finally closing cases have brought team members face to face with many perplexing situations, special problems, and gratifying experiences. Results also indicate interesting motivational dynamics that sometimes shift the balance between failure and success.

Among perplexing situations and special problems--perhaps the most dramatic is what help can be offered in a given case where word is received at 4:45 P.M. on Friday that Mrs. A is deathly afraid of bodily harm from her psychiatrically disturbed husband who has been undergoing vocational training; or handling the telephone call from Mrs. B. who is depressed from child problems, (apparently) psychosomatic symptoms, etc., and expressed a desire to take a massive dose of medication. Also, how does one rebound enthusiastically after a discussion in which a trainer-employer indicates the client wearing the artificial limb and tagged with a three c heart condition cannot meet production quotas in electrical bench work--when it is apparent that the employer is still more concerned about insurance rates even after thorough discussion. And, the frequent occurrences where clients faithfully promise but fail to keep appointments to see potential employers. The continuous monitoring of such unusual cases along with the routine follow-up required in the post-plan phase furnished a constant challenge to team members.

Amendments and revisions to plans were required quite often as might be expected with clientele having a high incidence of psychiatric emotional involvements. The decision as to whether a mentally or emotionally disturbed client, who were otherwise qualified, could undergo training at a given time was difficult. Readiness for training that involved new materials and a degree of complexity sometimes depended on finer discrimination than available at the time. Regardless of the normal psychological-psychiatric evaluation and knowledge of behavioral responses in prevocational classes and home environment, there was no valid assurance that some combination of stresses while in training or employment would not cause interruption of the plan.

It was a matter of record that few AFDC referrals were ineligible for service on the basis of no disability underthe constellation concept. Screen-out from referral was necessary in most cases on the basis of non-readiness for reasons such as lack of interest or intervening problems. The probability of success increased markedly if the client actually finished prevocational classes.

The cost factor involved in two categories of clients was determined at a point in the report period where cases successfully rehabilitated (N=51) were compared to cases accepted for service but not rehabilitated (N=24). The average success case cost of $565 compared to an average $158 for an unsuccessful case. The low cost shown for the latter would appear to indicate a high percentage of closures prior to initiation of the rehabilitation plan. This is not necessarily the case as shown in the full tabulation (Appendix "C", Table 28) where accepted but unrehabilitated closures before and after services were balanced at fourteen and fifteen respectively. The low cost of this closure category is more likely to be due to limited potential precluding all but relatively inexpensive on-the-job training. This assumption is confirmed somewhat by Group Means (Table 12) showing less years of schooling for failures than for successful clients.

Disappointment of the staff at client failures was offset by the gratifying experience of seeing another client and family become successful and happy, when perhaps, he had no prospect of this before. The example of Mr. Vargas reported in the February, 1967, issue of the periodical Rehabilitation Record is such a case. After a number of attempts on his life and that of his wife and prospects of a broken home, he and the family are now very happy and enjoying the fruits of his work.

Results in many cases indicate that the Team Approach is the basis for some interesting motivational dynamics in working with the AFDC client. In receiving conventional services from the SDPW and DVR, some clients do not necessarily identify their isolated caseworker and counselor as working partners. In fact when the caseworker refers the client to the DVR counselor, the client can perceive the referral and the counselor as a threat to his (very welcome) grant. The characteristically passive response to vocational rehabilitation assistance may be one outcome of this feeling. The contrast in dynamics is pronounced when the Project client is introduced to the counselor by his caseworker and he perceives that the two are, in fact, members of a team. Close team support for the client's goals appears to help him set his frame of reference and concentrate on the tasks ahead.

The Team Approach

A good portion of Project achievement can be attributed to what can be called the team approach. This means more than having two people, a counselor and caseworker, work on the same case or even work toward the same general goals. It is essential that they work together effectively toward coordinated client-family centered goals before the activity fits the description of good team work.

The requirement for team members to identify themselves with client-family centered goals is for the purpose of establishing mutual responsibilities. Services rendered can be expected to excel where team members are specialists and can effectively focus information, resources, and efforts without biases toward common goals.

Another requirement for good team work is coordination of action or working together effectively. If information, resources, and efforts are not coordinated as to effect, readiness, time, place, opportunity, etc., overall effectiveness of rehabilitation services may suffer—goals may not be acheived as economically or to the degree desired if acheived at all. The art of working together is enhanced by many personal and professional attributes which might well be considered in Project assignments.

In the final analysis good Project team work involves all the heretofore mentioned attributes descriptive of team members who enjoy responsibilities and professional identification with their respective agencies. In addition, esprit de corps and professional development may be heightened by the willingness to do a little more—make sacrifices if necessary to help client and family reach their rehabilitation goals. Good team work as demonstrated in the San Antonio Project can flourish most effectively in a project setting with joint housing.

Analysis of Prevocational Activity

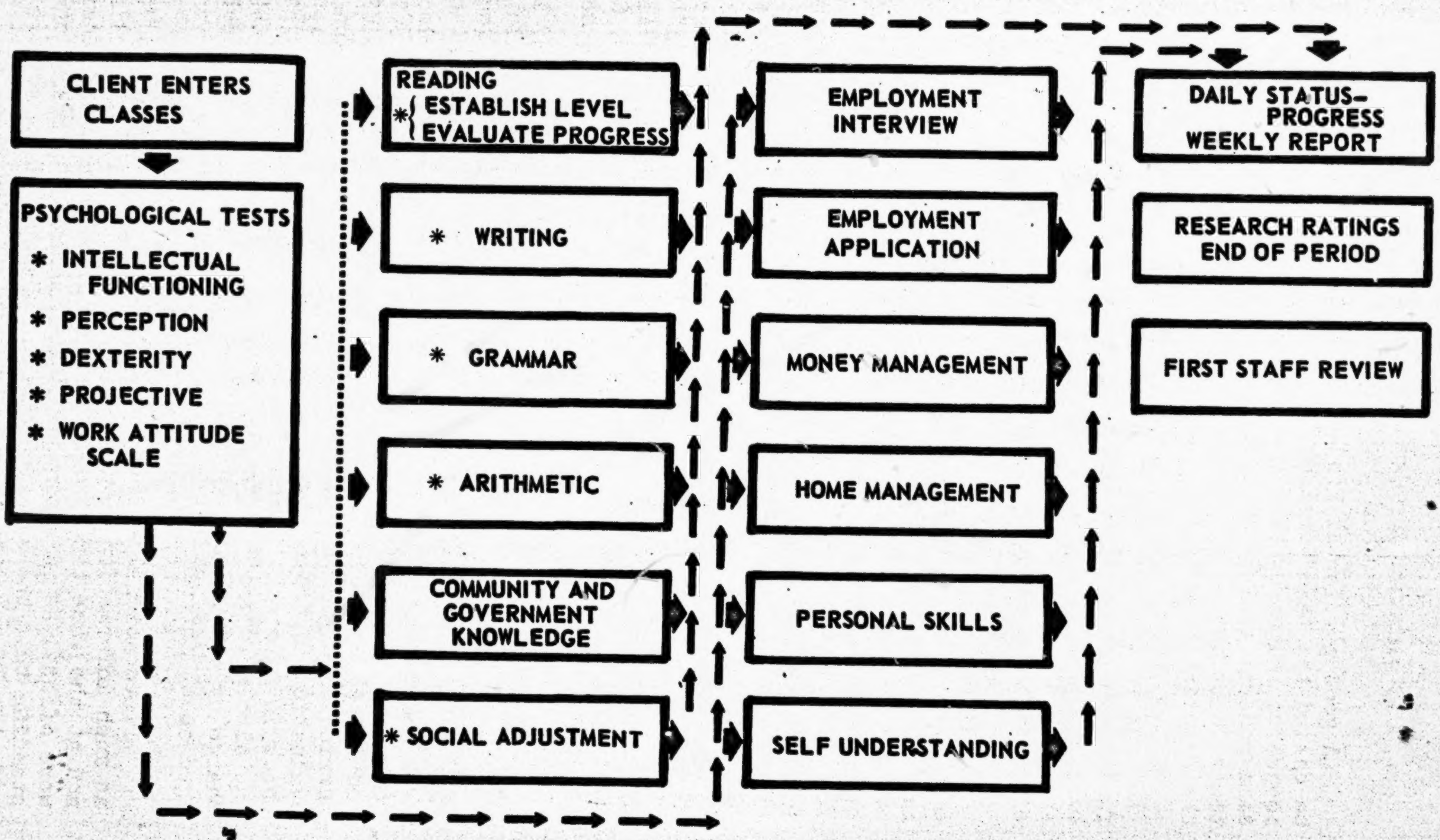
Prevocational classes were conducted under the sponsorship of a community non-profit organization. The organization provided administrative and fiscal services and delegated the technical responsibility for the curriculum to the Project Director by agreement. Tuition for the diagnostic evaluation-adjustment services were paid to the community organization which in turn paid the instructor's salary. Cost of class supplies, etc., was also paid from the same funds, but classroom space was provided free of charge by the San Antonio Public Housing Authority. The class size averaged about fifteen. These arrangments have proven very satisfactory.

Prevocational evaluation-adjustment activity served to make available as much information about the functional abilities of clients as possible and at the same time provided for maximum concomitant benefits. The classes were offered as an opportunity for vocational preparation with the understanding that the experience would also help team members to assist more effectively. Results of the response to this offer were followed step by step through the period.

CHART 2

CURRICULUM REVIEW

Pre-vocational Diagnostic Evaluation-adjustment


CLIENT ENTERS CLASSES
PSYCHOLOGICAL TESTS
* INTELLECTUAL FUNCTIONING
* PERCEPTION
* DEXTERITY
* PROJECTIVE
* WORK ATTITUDE SCALE
READING
* { ESTABLISH LEVEL
EVALUATE PROGRESS
* WRITING
* GRAMMAR
* ARITHMETIC
COMMUNITY AND GOVERNMENT KNOWLEDGE
* SOCIAL ADJUSTMENT
EMPLOYMENT INTERVIEW
EMPLOYMENT APPLICATION
MONEY MANAGEMENT
HOME MANAGEMENT
PERSONAL SKILLS
SELF UNDERSTANDING
DAILY STATUS–PROGRESS
WEEKLY REPORT
RESEARCH RATINGS END OF PERIOD
FIRST STAFF REVIEW

An excellent means of accomplishing academic and social diagnosis was found to be the exposure of the client and his group to a wide spectrum of guided experiences. Evaluation of functional abilities was simplified by assessing each client's reaction or response to the various experiences. The curriculum is given in Appendix "B" and a review of salient features is shown in Chart 2, Curriculum Review.

After entering class, the average client appeared to be adequately adjusted to the new environment in about ten days. As a matter of routine, then, a day for psychological testing was set as the second Tuesday in each month.

Results of psychological testing (ratings) were considered very useful in helping counselors determine strengths and weaknesses in client attributes. The interpretations prior to the research analysis shown in Table 12 were made on a relative basis without standardization on the San Antonio AFDC population.

The results in Table 12 compare three groups. Group one was successful in the rehabilitation process; group two completed the rehabilitation program but was not successful; and group three was closed out from referral. Preception, dexterity, and projectivity test means were determined for the three groups mentioned above. All three groups revealed different means; as an example, on perception, the mean for group one was 7.38 while the mean for group three was 3.16 suggesting that an individual in the future scoring at or above the mean for group 1 could be considered a suitable candidate for successful rehabilitation services in this one factor alone. When we consider all three factors, perception, dexterity, and projectivity tests, any one individual who falls at or above the means of group one would indicate a more favorable prognosis for success. While the scores on the Revised Beta examination are not indicated in Table 12, interpretations are similar. A score at or above the mean near six for group one on the Revised Beta would also suggest successful completion of the rehabilitation process. If a hypothetical individual was above the mean on group one on perception and manual dexterity but falls significantly below the mean on the projectivity, then the degree of successful prognosis becomes questionable. The counselor would recognize and job correlate his assets in perception and dexterity but would be directed toward assisting the client in recognizing the need and establishing better emotional stability.

This over simplification of possible procedures represents some considerations that might be used in addition to those presented in the more comprehensive prediction models in Section 13.

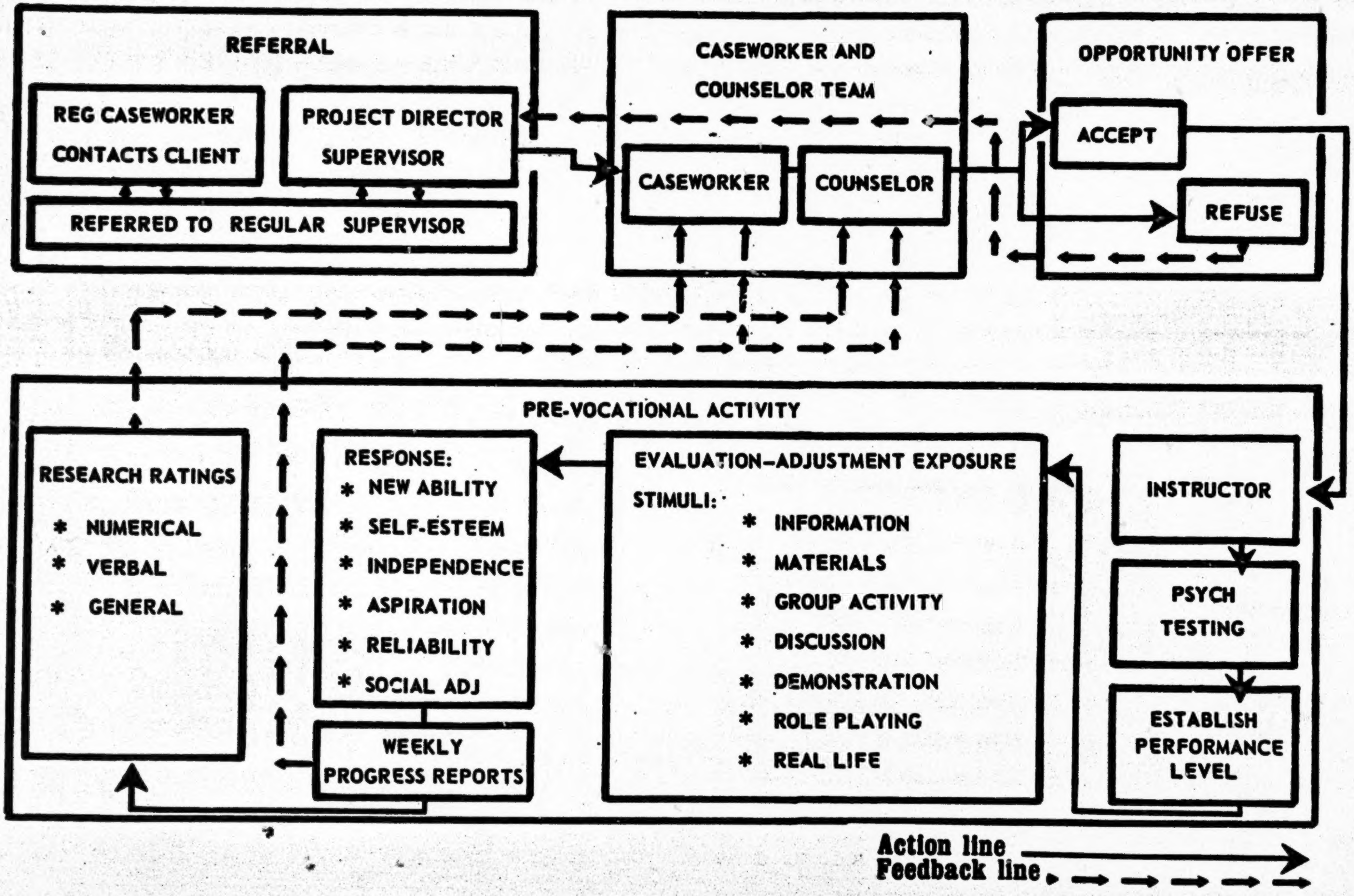
The results of establishing a functional level in the areas shown on Chart 2 indicate that the average AFDC client performed at about one-half his claimed years in school. After evaluating his progress over a two-month period, he had gained between 1.5 and 2.0 grade levels in functional ability. In the personal and social adjustment areas measurements were more subjective but in all cases showed marked improvements.

The methods for measuring client incoming and outgoing repertoire were considered more expedient than satisfactory for research analysis. Grade

CHART 3

SYSTEMS ANALYSIS

Pre-vocational Diagnostic Evaluation-adjustment


REFERRAL
REG CASEWORKER CONTACTS CLIENT
PROJECT DIRECTOR SUPERVISOR
REFERRED TO REGULAR SUPERVISOR
CASEWORKER AND COUNSELOR TEAM
CASEWORKER
COUNSELOR
OPPORTUNITY OFFER
ACCEPT
REFUSE
PRE-VOCATIONAL ACTIVITY
RESEARCH RATINGS
* NUMERICAL
* VERBAL
* GENERAL
RESPONSE:
* NEW ABILITY
* SELF-ESTEEM
* INDEPENDENCE
* ASPIRATION
* RELIABILITY
* SOCIAL ADJ
WEEKLY PROGRESS REPORTS
EVALUATION-ADJUSTMENT EXPOSURE
STIMULI:
* INFORMATION
* MATERIALS
* GROUP ACTIVITY
* DISCUSSION
* DEMONSTRATION
* ROLE PLAYING
* REAL LIFE
INSTRUCTOR
PSYCH TESTING
ESTABLISH PERFORMANCE LEVEL
Action line
Feedback line

level evaluation was made from performance in standard texts. Social response and improvement were arrived at judgementally. One question not settled in getting the Project underway was what array of evaluational devices would be satisfactory to measure the wide range of functional abilities. Some clients could not read, write or speak English and at the other extreme a few had completed high school. The need to investigate better means of measurement will be an objective for the future.

Experience thus far in accomplishing the behavioral objectives set out in the curriculum indicates that only a start has been made toward realizing the full results possible. More research in curriculum design should be followed by complete curriculum development including all means for the most effective presentation and evaluation. Since the activity was conducted by one instructor under the technical supervision of the Project Director (who also carried a caseload) there were never enough man hours available to maximize the effort.

The progress and end-of-period reports were discussed in Chapter II and will be evaluated in the following comments on Systems Analysis.

Systems Analysis. When fairly complex operations are initiated, it is only good management to try to see if money is being well spent—if the operation is doing what was intended. An analysis of prevocational evaluation-adjustment operations would be less meaningful without considering the whole system of related actions and responses. The systems analysis shown in Chart 3 includes four main blocks of activity (1) the referral, (2) caseworker-counselor team, (3) opportunity offer, and (4) prevocational activity.

Action was initiated in the referral block by the regular caseworker when the case was referred to the regular supervisor for Project service. The case was in turn referred to the Project SDPW Supervisor. If for some reason, the case could not be handled in the Project, the action reversed and the case returned along the same channels to the regular caseworker for continued field service.

After review by the Project Director and Associate Director, SDPW Supervisor, the case normally was introduced to the caseworker-counselor team along the solid action line connecting the referral action block to the team action block. Along with other diagnostic activity described in Chapter II, the team action most significant at this point to the prevoccation evaluation-adjustment function was the opportunity offer.

Action depicted by the solid line into the opportunity offer block could result in one of two client decisions. He could refuse and precipitate reverse action along the feedback line (dashed) to the referral block. If he accepted the opportunity for preparatory services leading to vocational activity, action continued along the solid line to contact with the instructor.

Action in the prevocational activity block progressed through psychological testing and action necessary to establish a functional performance level. This involved exposure to the special curriculum (Appendix "B") through use of various stimuli. The sequence of the stimuli was such that responses could be gradually amplified from a passive reaction to increasing active participation and application to real life situations. Application of stimuli logically lead to evaluation of pertinent responses. The responses shown i.e., "new ability, self-esteem, independence..." were noted in weekly progress reports giving day-by-day comments and anecdotes which were part of the feedback to the counselor-caseworker team. In addition to client progress, information available from group discussion concerning family conditions alerted the caseworker to special problems at an early stage. Finally, the research ratings were accomplished (scales Appendix "A") to reflect the readiness status of the client for further training and employment. This feedback to the team was timed to occur prior to the first staff review (Chart 1).

In the final analysis, the results must at least balance the efforts expended to be worthwhile. Results of this activity may be divided into benefits from (1) acquiring more functional ability, (2) better personal and social adjustment, and (3) the very tangible informational feedback to the team. For the AFDC client, it is reasonable that benefits from any one of the three areas could be well worth the sixty dollars per month tuition expended. Even with inadequate measurement to confirm or deny, there is reason to believe that the total impact of prevocational evaluation-adjustment classes far outweighs the resources expended.

Impact of Prevocational Activity

There are few changes more pronounced than the change toward better appearance that occurs invariably between initial interview and completion of class activity. Other changes are observable from advances in functional ability which is directly related to success as shown in this report. However, the most dramatic impact occurs in those who readily accept change.

The application of controlled group dynamics makes possible the use of social forces in a way not usually felt in the client's everyday environment. In his home neighborhood where many families are on the welfare roles, it is very acceptable to be a martyr to disability, insufficiency, and dependency. His self image is usually shallow, distorted, and inadequate. He may or may not be aware of an emotional overlay which influences his reaction to most life situations. In contrast to these influences, the prevocational group environment is much different. It is very satisfying to see and hear members of the class prepare for and make presentations on vocational outlook, self care, home management aspects, and other topics of importance. Successful former class members are invited to give interesting presentations on their experiences. One 33-year-old woman client (high school graduate) studying to be an X-ray technician has been so influential that she is scheduled regularly to return each two months. It may be hard to imagine the AFDC client using role-playing techniques in practicing the employment interview. One reason for a degree of success with most participants is that stimuli are introduced through behavorial objectives. The object in all cases is to do something, such as explain, perform, describe, compute, write, discuss, and other actions. In this special group setting, conformity must be in terms of action rather than more characteristic inaction. All participating clients benefit in varying degrees as evidenced by performance.

It is quite obvious that more research is needed to give greater detail about what is happening, how it is happening, and how to maximize the benefits.

Special Problems

A number of special problems developed in the course of Project operation. Many of these have been resolved by attention to operational procedures as described in the body of this report; however, some problems persist and require special attention.

Child-care service for female clients has been a very special problem during prevocational classes and training. After exhaustive efforts to help resolve the problem for some prospective clients, there was no choice but to screen them out of the Project. Usually, there is less difficulty if the client has relatives in the community, but some have no relatives or friends to help. The only practical solution appears to be free or very inexpensive services furnished through community sponsorship. This is discussed in Section 14 under Resultant Actions.

Movement of cases has continued to be a problem from time to time because the Project "pipeline" is limited by the number of cases the workers can handle. There are two areas of concern involved: the size of the caseload for intensive service and the period of time that can be given to an unmoving or stalled case.

Experience indicates that intense case service of the degree needed for AFDC cases cannot be given if caseloads are much larger than forty or fifty for caseworker and counselor alike. When excessive caseloads are handled, one can expect only the more able and better adjusted clients and families to achieve a reasonable level of success; likewise, the number of failures can be expected to soar. This condition would not give the team enough time on target to assure the client an optimum chance for success. In effect it might be considered a negative service in that any and every failure could be expected to create more inhibition.

The maximum period of time for holding cases not expected to move constructively was set at about six months to preclude blocking-out other clients who could take advantage of complete Project services at once. For example, if physical restoration services could not be performed for a period of nine months, the case could be transferred back to the regular AFDC caseworker for routine service and re-referral at the appropriate time. This has almost but not completely solved the problem of "blocking the pipeline." Team members sometimes become so involved in cases that there is a tendency to hold on longer to provide additional services that could be provided elsewhere.

Staff communication essential for optimum team work has been a problem at times. The rapid pace at which counselors and caseworkers move make routine daily communication difficult even with joint housing. Team coordinated casework is most effective when communication occurs with the events. A thirty minute get-together period each Monday starting at 8:00 A.M. was tried, but so many other commitments intervened that it was only partly effective. Notes left on the desk of a team member have helped until face to face discussion could be effected

Staff reviews served as a summary of team communication and activity. Early in the Project this time was used to actually arrive at certain major decisions in the case, i.e., eligibility, plan progress, and success. The discussions invariably included so many smaller details that soon the amount of time spent became prohibitive. Then, a special form was constructed for the team to use in documenting only pertinent information and team decision before staffing. The staffing then was held for the team to review action with supervisory personnel. The latter procedure was most effective.

SECTION 13

UTILIZING THE PRESENT RESEARCH IN THE WELFARE - REHABILITATION SETTING

It has been stressed repeatedly in previous sections that the results obtained to date are based only on the initial years of the San Antonio Demonstration Project. They should be checked and verified in other settings with sets of individuals who clearly differ, descriptively, from the San Antonio clientele. At the same time it is obvious to researchers and workers alike that unless these results lead to suggestions for practice, they constitute an empty statistical exercise and should be disregarded as the idle play of flaccid minds. Therefore, this Section of the report will summarize the previous portions and will attempt to point up their apparent salience for the rehabilitation of the urban poor. It should be kept in mind constantly by the practitioner, however, that the inferences attempted and the suggestions offered are directly and safely applicable only to client populations resembling that dealt with in San Antonio. Extensions of our inferences and suggestions to markedly different client groups in other situations must be made with caution and "common sense" until adequate validations of our findings in such settings are at hand. "Facsimile" testing of the San Antonio experience is highly necessary.

Decision - Making and Prediction

At the outset of the San Antonio Rehabilitation - Welfare Project, there were very few bases for confidence in either (a) the selection of referred clients who would be most likely to persist in the rehabilitation process, or (b) in forecasts about what kind of selected clients would achieve greatest "success" in terms of gains in either independent incomes or in reductions in their receipt of welfare funds. In consequence, referrals (for possible service) to the Rehabilitation Staff were controlled by broad criteria such as a client's age and a judgment of apparent or assumed disability.

Obviously, it would be uneconomic financially and a profligate waste of limited rehabilitation staff and resources unless worthwhile progress could be made on the twin problems noted above. Studies were needed to enable one to select "good risks" more discerningly from the total pool of potentially referrable welfare clients. Furthermore, initially available diagnostic data for any selected clients should be, with some confidence, useful in forecasting probable degrees of client benefit from the rehabilitation process. On the basis of prediction, areas of deficiency can be determined for intensive remedial action. In this way more people might be helped to take advantage of rehabilitation services.

Those involved in the San Antonio Project from its beginning were keenly aware of the two kinds of practical decision, or prediction, needs just indicated. Therefore, they devised their program for studying clients so as to encompass a very wide range of assessments of the medical, educational, social, and psychological attributes of the target population. These assessments, whether anchored in the observations of caseworkers, in the instrumented observations of a physician, or in tests administered by a clinical psychologist, a counselor, or a teacher, were then converted to ratings on explicitly defined 9-point scales for each individual. These ratings, for the first 113 cases, were subsequently subjected to factor-analytic examination. The object of these analyses was to discern whether or not the initially diverse and numerous individual assessments might be reduced to a more economical battery for future use in constructing each client's individual profile of strengths and limitations. The results described in Section 10 of this report indicated that such an economizing might be possible without too great a loss of information possessing value to the rehabilitation counselor or educator.

A Minimum Client Assessment Battery

The minimum client assessment battery which we would suggest would include ratings of the following variables:

1. Numerical ability
2. Intellectual functioning
3. Projective assessment
4. Attitude toward training (rating)
5. Time management rating
6. Personal hygiene rating
7. Cardiovascular condition
8. Neurological status (physician's rating)
9. Respiratory system

10. Gastrointestinal and Genitourinary systems (physician's rating)

11. Attitudes toward Self, Others, and Work (Work Attitudes Scales)

12. Autonomy and Ambition (Work Attitudes Scales)

Cutting the total client assessment (intake) program down to the 12 variables just listed would, necessarily, result in some loss of information which, in a given case, might have great clinical importance. Our suggestion, then, would be that these 12 attributes be assessed at intake for each prospective client. At the same time, provisions should be made for the collection (in individual cases) of such additional diagnostic assessments from the complete, original battery as might appear useful in (a) planning a given client's rehabilitation program, (b) counseling with him, or (c) forecasting either his likelihood of persisting in (vs. "droping out of") the rehabilitation program or his probability of profiting from the rehabilitation effort. Not all such variables are included in the minimum assessment battery suggested to us solely from factor-analytic studies.

Persisting in a Rehabilitation Program

Among the San Antonio Project's clients in this study, there were three discernible groups of persons: (1) people referred to the Project but not accepted for rehabilitation efforts; (2) others who were referred and accepted but who discontinued the rehabilitation program; and (3) individuals who were referred and accepted and who completed the program. The question necessarily arose as to whether or not certain characteristics, which could be known at referral or intake time, might clearly differentiate among these groups. Most obviously, when resources are limited, rehabilitation efforts should be expended first upon those who are most likely to "stay with it to the end."

Reference to Tables 12 and 13 of this report suggest that forecasts of client persistence in the rehabilitation process could probably be made with some accuracy. The clinician or counselor who wished to make the key discrimination - that between (1) "completers" and (2) "discontinuers" - should pay special attention to the fact that the former group differed from the latter, significantly and substantially, in the following rated characteristics:

1. Numerical aptitude (Completers excelled Discontinuers)

2. Verbal aptitude (Completers excelled Discontinuers)

3. Projectively assessed adjustment (Completers excelled Discontinuers)

4. Rated family affection (Completers excelled Discontinuers)

When a substantially larger sample of clients is studied, relatively accurate prediction equations can be generated to make this judgment of likely group membership more precise.

Predicting Relative "Success" in Rehabilitation

How may individual differences in the relative "success" of vocational rehabilitation be judged? Can such differences be at all adequately accounted for, "explained," understood, or "predicted" by items of information (variables) which could be measured at the outset of a client's rehabilitation program?

The first of these questions obviously poses a dilemma in the realm of values. For example, should the client's own "satisfaction" with himself be taken as a key variable in a "success" definition? Should variations in increased weekly earnings or in decreased monthly aid from public welfare funds be construed as success indicators? The problem is a complex one morally, socially, and psychologically. It is a problem which we have resolved only in operational ways for the present investigation. Because of the nature of the data available, we chose to construe degrees of "success" in terms of two economic indicators:

1. Decreases in amounts of public assistance funds received.

2. Increases in weekly earnings.

The previous Section of this report has described the results of multiple linear regression studies undertaken to develop equations which can be cautiously applied with individual cases to predict probable "success" in terms of the two criteria noted above. The use of such equations in practical cases has also been described (Table 6 and 7). In general, it has been shown by this study that the two criteria of "success" may well be substantially, but not perfectly, predictable.

Of greatest interest to social welfare agencies and workers and to practicing vocational rehabilitation counselors should be the findings presented in Tables 10 (page 48) and 11 (page 49).

Table 10 shows that decreases in individuals' public assistance receipts could have been reasonable well predicted (R = .77) at the time of client intake from Diagnostic Evaluation Format variables. The counselor could have taken account chiefly of the client's sex, his criminal and work histories, the number of years of his formal schooling, the physician's judgment of respiratory health, the client's rated intellectual functioning and perceptual ability, and his score on Scale I of the Work Attitudes Scale.

From Table 11, the practitioner can gain some assurance that, in this client population at least, individual client's increases in weekly earnings (associated with his rehabilitation) depended quite strongly (R=.68) on a previously steady work history, extensive vocational training, and adequate intellectual functioning. The client's age at referral, his respiratory status, and his projectively assessed psychological condition also contributed to predicting the criterion.

It is worth careful note here that the two "success" criteria focused on in this study were not effectively predictable from the same sets of Diagnostic Evaluation Profile variables. For example, the client's history of felonious crime entered heavily (with a negative weight) into predicting decreases in public assistance funds received, but did not appear as an effective forecaster of increases in weekly earnings. Other differences between the two criterion prediction models can be readily observed by the readers of Tables 10 and 11.

The Need for Cross - Validation

In considerable degree, this study must be viewed as a beginning in the research - demonstration tasks which confront rehabilitation workers across the nation. Certainly the conclusion cannot be drawn legitimately that we have produced universally, or perhaps even widely, applicable prediction equations. San Antonio, Texas, is not Amarillo, Texas, much less Minneapolis, Minnesota or Portland, Oregon.

A beginning has been made, we think, in clarifying a very complex research area. Our results must, however, be tested and tested again in varied communities over a period of years so that large groups of clients can be studied and followed up with very great care. Ultimately, we would hope that the difficult problems of diagnosis and prognosis which have been attacked in this study would be resolved with greater conclusiveness than is now possible.

SECTION 14

Conclusions, Resultant Action, and Recommendations

Conclusions

The results of Demonstration and Research show that the separate State agencies involved were able to work together systematically and effectively under the conditions described to offer specialized professional services to AFDC recipients and families. The percentage of disabled Welfare clients who were successful in becoming rehabilitated (38% of all closures - 70% of accepted closures) was markedly better than the often quoted national average of two percent. The spin-off benefits in terms of evaluation research have established pertinent research information, prediction guide lines and specific prediction models that promise to be useful in working with the San Antonio AFDC clientele. These conclusions are possible as the result of accomplishing most of the basic objectives set out as Project goals.

The objective, to establish an adequate referral system, was successfully carried out by developing and improving procedures for referral (see Resultant Actions for latest referral development). The fact that the sampling was not as representative of the total AFDC population as hoped for does not detract from the system or the results but may be indicative that referral under the research criteria was influenced by an important attribute of a good caseworker—responsiveness to need.

Development of a comprehensive and routine social-vocational diagnosis and plan for rehabilitation has contributed to success in providing timely and effective services. This effort has been maximized by the team approach.

Analysis of special costs shows that an average of 560 dollars was spent through DVR case services vouchers for successful cases. This amount can be quickly offset through male employment and elimination of grant. Female employment on the average requires a slightly longer period for amortization because some females with less potential earning power continue to receive supplemental assistance to fulfill economic needs. The 158 dollars spent to give accepted but unsuccessful clients a chance to be independent is considered insignificant compared to the costs of dependency. In the final tabulation only 15 percent of all closures were in the above category (47 percent screened-out from referral, 15 percent accepted unsuccessful, and 38 percent successful).

Experience has shown that intensive case work was required by the counselor and caseworker to facilitate client-family progress. The counselor-caseworker working ratio of one to one was effective in providing the service. The average client had multiple vocational handicaps and liabilities, and the average family had complex problems and inhibitions. Frequent contact was necessary in most cases. Timing as well as appropriateness of service was essential to success in many cases. Although the team approach was conducive to intensive service, it cannot guarantee case service of any particular intensity unless case loads are limited appropriately.

No definite conclusions are presented as to the nature or comparison of Latin-American ethnic characteristics that may deter or accelerate the possibility of vocational rehabilitation. This subject may deserve further study in regard to broad characteristic as compared to those of the various ethnic groups receiving AFDC. The comparison of various ethnic groups receiving AFDC may also furnish valuable information in the future.

One of the most promising features of the demonstration work has been the prevocational evaluation-adjustment activity. Just how much impact was produced and how near its potential has been reached is an open question. It is significant that many of the factors in the prediction models are directly or indirectly affected by this activity. This is considered an important area for future investigation.

Through the use of evaluation research, a beginning has been made in clarifying a very complex research area. The most significant research finding is that prediction of success or failure in rehabilitation can be made with considerable confidence for the San Antonio AFDC clientele. This finding can be used in a number of ways, one of which may be to help locate areas of deficiency likely to contribute to failure. If specific remedial action can be taken with sufficient time on target, many more cases of rehabilitation success may be possible. Experience with remedial efforts may eventually indicate a new and lower threshold for rehabilitation success below which time and money spent may be unproductive.

This report is given in sufficient detail so that, if desired, facsimili reproductions of this Project can be implemented elsewhere for validation and possibly for regular program use. It is our considered conclusion that similar cooperative projects can contribute equally well to strengthening our society in any state where top, middle and first line management will give equally enthusiastic support.

Resultant Actions

On the basis of experience gained from Project activity, the parent agencies have entered into an agreement to work together in a number of cooperative projects on a statewide basis. Projects are planned for all districts with relatively large AFDC populations.

The importance of further research and development in all aspects of the prevocational activity has been recognized by the Federal government to the extent that a special grant extension has been made for this specific purpose. The best available knowledge and resources have been acquired by contract with a private group of evaluational research associates. Developmental work will be underway through 1967 and a full report is expected early in 1968.

Community sponsorship of prevocational class activity was changed from a local organization called Action for Community Development to an old line National-State-Local organization known as the Mental Health Association of Bexar County. The purpose was to obtain the services of an organization with good community cross sectional representation, one active in all medium to large Texas cities, and one which might possibly be available for similar assistance on a state wide basis. This non-profit organization appointed a special committee called the Community Prevocation Committee (CPC) composed of an insurance representative, banker, lawyer, Veterans Administration representative, San Antonio Housing Authority representative, and otherbusiness and manufacturing people. This organization set cost-based tuition for class participants, paid salaries and operating expenses, and handled administrative and fiscal details subject to periodic organizational audit. The technical guidance and responsibility for details of curriculum was retained (as before) by the Project Director.

In order to help solve the child care problem for mothers undergoing prevocational classes, arrangements have been made to acquire a day-care center located near the adult prevocational classroom. The center will be under the same sponsorship (Mental Health Association of Bexar County) as prevocational classes and technical guidance will be given by the Associate Project Director.

The State Department of Public Welfare is developing a new approach to AFDC referral. An information form is completed for each AFDC recipient and a copy sent to the Project office for referral consideration. The form contains general information, disability information, attitudinal rating, readiness for vocational activity, and time priority recommendation. The "readiness for vocational activity" and priority recommendation help Project Staff in scheduling clients well in advance. From the standpoint of Project operations, this system promises to be the most effective yet. Its use on a State-wide basis is planned and can add to the effectiveness of cooperative efforts.

The San Antonio Project has been undergoing growing pains during the last five months. Two more caseworkers have been moved in, two newly hired counselors have been added, and the Project Director has been freed of casework in order to be more effective in management and to coordinate in the continuing research and development activity. As of this writing all personnel are still crowded into the original space; however, half the staff will soon be moving upstairs into newly renovated offices with a view of HemisFair 1968.

Recommendations

Many of the recommendations which might be expected from experience gained in this Project are already being put into effect as directed by management of the two agencies. These activities were described previously under Resultant Actions. The progress toward a state-wide network of cooperative projects, improved state-wide AFDC referral system, further research for optimum benefits from prevocational classes, better community involvement in prevocational and Project functions, and expansion of the San Antonio Project are very gratifying to Project personnel. Additional recommendations are as follows:

When a number of cooperative projects are operative over the State, it is recommended that the research results reported here be tested on the different ethnic groups involved. Evaluation and reporting might be done by an outside authority as before.

As the network of cooperative projects is implemented, it is suggested that parent agencies publish and maintain specific directives for the activity. This might take the form of supplements to standard agency manuals or a coordinated composite manual of operations for project use.

A staff development program for the project network is recommended for assuring adequate training and performance standards and for disseminating newly developed information and techniques. This should include periodic workshops for experienced staff members and special indoctrination for each new project staff. Each new member of a project should be given similar training by the receiving staff.

BIBLIOGRAPHY

McWhorter, Clyde C. and Lamonte, Antoinette J. "Why Welfare: 'Employment at Record High--Employers Seeking Workers for Jobs'." Rehabilitation Record, February, 1967.

Beck, Robert B. Demonstration and Research Design: Welfare-Rehabilitation Project. San Antonio, Texas, 1964.

Lindzey, Gardner (Ed.) The Assessment of Human Motives. New York: Rinehart, 1958.

Miller, S.M. "The Study of Man. No. 3. Evaluating Action Programs." Trans-action, 1965, 2 (3), 38-39.

Pierce-Jones, John. Rehabilitation-Welfare Demonstration Research in San Antonio, Texas: A Progress Report on Evaluation. Austin, Texas: The University of Texas (Personnel Services Research Center), July, 1965; 37 pages (Mimeographed).

Thorndike, R.L., Hagen, Elizabeth. Measurement and Evaluation in Psychology. New York: Wiley, 1961.

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APPENDIX

A

CRITERIA FOR EVALUATION

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DIAGNOSTIC EVALUATION FORMAT

NAME______________________________ DATE______________________________

I. Marker Information (Coding Found in Criteria Section)

A. Noncontinuous Data

1. Sex ______________________________
2. Race or Ethnic Group ______________________________
3. Religion and Participation ______________________________
4. Housing ______________________________
5. Primary Language ______________________________
6. Marital Status ______________________________
7. Police Record ______________________________
8. References ______________________________
9. Work History ______________________________
10. Previous Vocational Training ______________________________
11. Previous VR Experience ______________________________
12. Telephone ______________________________

B. Continuous Data

13. Years in School ______________________________
14. No. of dependents ______________________________
15. Amount of Total Welfare ______________________________
16. Amount of Monthly Welfare ______________________________
17. Length of Time on Welfare ______________________________
18. Year of Birth ______________________________
19. Age ______________________________

DIAGNOSTIC RATINGS

	9	8	7	6	5	4	3	2	1
II. Appearance Status									
20. Personal Hygiene									
21. Clothing									
22. Aesthetic									
III. Physical Status									
Peripheral									
23. Oral Hygiene									
24. Muscle (including Hernia)									
25. Bone									
26. Respiratory									
27. Cardio Vascular									
28. G. I. & G. U. Systems									
29. Endocrine & Weight									
Neuro Sensory									
30. Neuro									
31. Sight									
32. Hearing									
IV. Mental, Aptitude Status									
Academic									
33. Numerical									
34. Verbal									
35. General									
36. Intellectual Functioning									
37. Perception									
38. Dexterity									
V. Emotional Status									
39. Projective									
Attitudes Toward									
40. Family									
41. Government									
42. Training									
43. Child Education									
VI. Family Status									
44. Affection									
Management									
45. Money & Equivalent									
46. Time									
47. Resources for Recreation									
Health									
48. Hygiene of Family									
49. Home Sanitation									
50. Degree of Family Illness									
	9	8	7	6	5	4	3	2	1

CRITERIA

I. Marker Information

A. Noncontinuous

1. Sex
    - a. F — Females
    - b. M — Males
2. Race or Ethnic Group (to be completed by counselor)
    - a. WA — White-Anglo extraction
    - b. WL — White-Mexican extraction (Latin American)
    - c. AL — Mixture of Anglo, Mexican extraction
    - d. N — Negro
    - e. M — Mongolian
    - f. O — Other
3. Religion and Participation (to be completed by caseworker)
    - a. CP — Catholic, Constant Participator
    - b. CO — Catholic, Occasional Participator
    - c. CN — Catholic, No Participator
    - d. PP — Protestant, (ie. above)
    - e. PO — Protestant, (ie. above)
    - f. PN — Protestant, (ie. above)
    - g. JP — Jewish, (ie. above)
    - h. JO — Jewish, (ie. above)
    - i. JN — Jewish, (ie. above)
    - j. O — Other
4. Housing (to be completed by caseworker)
    - a. GN — Good housing, good neighborhood
    - b. GP — Good housing, poor neighborhood
    - c. PG — Poor housing, good neighborhood
    - d. PP — Poor housing, poor neighborhood
    - e. PH — Public Housing
5. Primary Language (to be completed by bi-lingual person if possible)
    - a. E — English only
    - b. ES — English primary, Spanish secondary
    - c. SE — Spanish Primary, English secondary
    - d. S — Spanish only
    - e. O — Other
6. Marital Status (to be completed by caseworker)
    - a. M — Married
    - b. S — Separated
    - c. D — Divorced
    - d. CM — Common law marriage
    - e. W — Widow or Widower
    - f. U — Unmarried or single
7. Police Record (to be completed by caseworker)
    - a. N — No record
    - b. M — Misdemeanor
    - c. F — Felony record

8. References (To be completed by counselor)
   a. A — Appropriate response (including combination of former employers, character and/or credit references)
   b. L — Limited response (desire to give only one or two names, usually neighbors)
   c. U — Inappropriate response (usually wants to give relatives or cannot respond)
9. Work History (To be completed by counselor)
   a. SI — Steady work history up to immediate past
   b. SD — Steady work history in distant past
   c. WS — Spotty work record
   d. NW — No work record
10. Previous Vocational Training (To be completed by counselor)
   a. EV — Had extensive vocational training
   b. SV — Had some vocational training
   c. NV — Had no vocational training
11. Previous Vocational Rehabilitation Experience (To be completed by counselor)
   a. PTP — Prosthetic (and/or other physical restoration), training services
   b. P — Physical restoration only
   c. T — Training and placement only
   d. NVR — No previous VR experience
12. Telephone Service (To be completed by caseworker
   a. Yes
   b. No.

B. Continuous

13. Years in school, education as reported by client (To be completed by counselor)
14. Number of dependents, not including client (To be completed by caseworker)
15. Amount of money received (total) from all welfare agencies (To be completed by caseworker)
16. Amount of money received monthly from DPW (but to include other welfare agencies) (To be completed by caseworker)
17. Length of time on welfare rolls (To be completed by caseworker)
18. The year of birth, last two digits only (To be completed by counselor)
19. Age at time of referral to project (To be completed by counselor)

II. Appearance Status

This section will include only ratings for the client, and not for the whole family. Since the purpose of the project is to upgrade the clientele's circumstances, it seems important for the sake of objectivity to complete this rating at the completion of the first counseling interview. These ratings will be done by the counselor and not the caseworker (reason for this decision includes the hope that meaningful comparison of the professional staffs' rating--the caseworker will do the family status ratings--can be accomplished, and the client coming to the office can be likened more to his entering an employer's office than can the caseworker's contact with the client at home.)

20. Personal Hygiene

The meaning of this term is analogous to cleanliness and/or sanitary habits, the object being to take preventative measure for healthful living.

Definitions of Levels in Scale

9 Evidences the following: clean body and extremities, dental care, clean clothing, good posture, weight control, prudent use of patent medicines (disinfectants, aftershave lotions, skin creams, mouth washes, etc.), and has made adequate use of medical resources.

8 Includes most of the above but omits focusing attention on one or two items--leaves impression client puts forth effort to maintain self at highest level possible.

7 Client leaves impression his daily living habits include some hygienic activities and is motivated or concerned to some extent to live by reasonable health standards.

6 Complies with living (health) standards mostly by habit, evidences a little concern for hygienic self-care.

5 Habitual type self-care which appears to indicate little understanding of taking preventative measures. Impression is that hygienic habits exist more because of social pressure than for sanitary purposes.

4 Some social awareness of self-care with habits to correlate, but evidences lack of concern for self-care activities.

3 Recognizes something wrong with health, but evidences sloppiness in self-care activities. Evidences a little awareness of social factors related to hygienic habits.

2 Includes most of items in level one but has made some efforts to cover characteristics--detremental.

1 Evidences the following: dirty body and extremities, poor dental care, dirty clothing, poor posture, no weight control, omission or misuse of patent medicines, ignoring medical resources--detrimental.

21. Clothing

9 Appropriate dress, good condition of clothing, proper coordination of clothing items.

8 Good condition of clothing, fair degree in appropriateness of dress, evidence of effort to coordinate clothing items.

7 Fair condition of clothing, evidences of some effort to coordinate clothing items, little evidence to indicate concern for appropriateness of dress, but not necessarily inappropriate.

6 Fair condition of clothing, most clothing items reasonably coordinated, good state of maintenance.

5 Fair condition of clothing for state of maintenance (ironed, buttons on, shirt tucked in, etc.).

4 Poor condition of clothes, optimum state of repair.

3 Poor condition of clothes, fair state of repair.

2 Poor condition of clothes, no evidence of repair, does not have all essential items.

1 Ragged clothing, many essential items missing, clothing cannot be repaired.

DEFINITIONS

Appropriate dress: acceptable and standard to the working environment (this includes the idea of putting "your best foot forward"). The first interview might be likened to the client making a job application.

22. Aesthetic

Assumed to be analogous to attractive - unattractive.* For this item, the frame of reference includes only that of thinking thought to be most common for employers when hiring personnel.

9 Above average attractiveness.

8 General attractiveness.

7 Pleasing appearance suppresses displeasing qualities.

6 Pleasing appearance but some displeasing qualities secondarily noticed.

5 Neither considered attractive or unattractive.

4 Displeasing characteristics noticed but some pleasing characteristics secondarily noticed.

3 Displeasing appearance suppresses pleasing characteristics.

2 General unattractiveness.

1 Extreme unattractiveness.

*Attractive - Unattractive

Regular or irregular features (bone and teeth structures), good or poor skin texture (including facial blemishes), hair styling is good or bad (bad might mean "pachuco" orientation), degree disabilities are noticeable, degree of appropriate-inappropriate mannerisms (includes sex conditioned mannerisms), degree of appropriate-inappropriate usage of cosmetics (includes hair oil for men).

III. Physical Status Scale

The medical consultant will do these ratings at his regularly scheduled visits to the office. The information with which he will have to work will be general physical examination evaluations from primarily one examining physician. If after the medical consultant has reviewed the information and he feels special examinations are in order before he can complete the ratings on a given case, then these special examinations will be scheduled and authorized by Vocational Rehabilitation.

On those cases where physical restoration services are in order, the medical consultant will review the case at the completion of the services to determine the change in physical status. In addition, any team worker may request that he review a case if unanticipated problems should arise.

In order to have a reliability check of these ratings, it has been decided that the consultant will keep a list of diagnoses and the corresponding ratings so that after a period of time has lapsed, the scores can be compared with the diagnoses. This field sheet of diagnoses and their corresponding ratings will not be used to decide future ratings, thereby, prevention of systematic bias has been included in the procedure.

Definitions of Scale Level Items

9 No limitation on activities.

8 No limitation with medical supervision.

7 Minimum limitation without medical supervision.

6 Minimum Limitation with medical supervision.

5 Moderate limitation with or without medical supervision.

4 Moderate limitation with medical supervision and possible prospect for improvement.

3 Limited activity as defined by medical authority through supervision.

2 Minor activity as prescribed through medical supervision.

1 Very little or no activity as prescribed through medical supervision, needs constant medical attention.

DEFINITIONS

1. Minimum limitation: Can do almost anything but knows there is something wrong because he does not feel up to "par" after day's activities.
2. Moderate limitation: Limits own activities because he knows he will be incapacitated for an indefinite period of time if he attempts to function in activities beyond his capacity.
3. Limited activity: Limited activity as prescribed by medical authority.
4. Minor activities: Very little activity and the permissible activities are prescribed by medical authority.

AREAS TO BE EVALUATED BY MEDICAL CONSULTANT

A. Peripheral

- 23. Oral hygiene
- 24. Muscle including hernias
- 25. Bone

B. Bone

- 26. Respiratory
- 27. Cardiovascular
- 28. G. I. and G. U. Systems
- 29. Endocrine and weight

C. Neuro-sensory

- 30. Neuro
- 31. Sight
- 32. Hearing

IV. Mental Aptitude Status

A. Academic

These three ratings were done by the director of the Prevocational Diagnostic Evaluation Sessions. This individual rates the clients according to this criteria after he has an opportunity to work with them for two to three months, working everyday, six hours a day (the curriculum for these sessions may be found in Appendix B). We were not able to obtain these ratings on all of the referrals to the project primarily because in order to obtain these ratings, there is the necessity of the client agreeing to attend daily sessions.

33. NUMERICAL NINE-POINT SCALE FOR PREVOCATIONAL DIAGNOSTIC EVALUATION

9 Able to work with numbers (addition, subtraction, multiplication, division, fractions, decimals, and percentages) in written or problem solving form at the 6th to 7th grade level.

8 Able to work with numbers (addition, subtraction, multiplication, division, fractions, decimals, and percentages) in written or problem solving form from the 5th to 6th grade level.

7 Able to work with numbers (addition, subtraction, multiplication, division and fractions) in written or problem solving form from the 4th to 5th grade level.

6 Able to work with numbers (addition, subtraction, multiplication, and division) in written or problem solving fashion from the 3rd to 4th grade level.

5 Able to work with numbers (addition, subtraction, multiplication, and division) in a written fashion from the 2nd to 3rd grade level.

4 Able to work with numbers (addition, subtraction, and multiplication) in a written fashion at the 2nd to 3rd grade level.

3 Able to work with numbers (addition, subtraction, and multiplication) in a written fashion at the 2nd grade level.

2 Number values, in written fashion, understood at a low level only in simple addition and subtraction (1st grade level).

1 Lack of understanding number values for simple addition and subtraction either in written or verbal form (beginner's level).

34. VERBAL NINE POINT SCALE FOR PREVOCATIONAL DIAGNOSTIC EVALUATION

9 Able to speak and understand English at the adult level for most job opportunities in semi-skilled work. Able to read and write from the 6th to 7th grade level. Verbal and written freedom of expression and communication good.

8 Able to speak and understand English at the adult level for most job opportunities in semi-skilled work. Able to read and write from the 5th to 6th grade level. Verbal and written freedom of expression and communication fair.

7 Able to speak and understand English at the adult level for most job opportunities in low semi-skilled work. Able to read and write from the 4th to 5th grade level. Verbal and written freedom of expression and communication weak.

6 Able to speak and understand English at a level commensurate with that required to perform some of the higher unskilled labor jobs. Able to read and write from the 3rd to 4th grade level. Verbal freedom of expression and communication weak. Written freedom of expression and communication very difficult.

5 Able to speak and understand English at a level commensurate with that required to perform middle unskilled labor jobs. Able to read and write from the 2nd to 3rd grade level. Verbal freedom of expression and communication almost negligible.

4 Able to speak and understand English at a level commensurate with that required to perform middle unskilled labor jobs. Able to read and write at the 2nd grade level. Verbal freedom of expression and communication very poor. Written freedom of expression and communication negligible.

3 Able to understand, but not speak English at a level commensurate with that required to perform low unskilled jobs. Ability to read and write at 1st grade level. Verbal freedom of expression and communication almost negligible. Written freedom of expression and communication unable.

2 Weak ability in understanding English and no ability to speak English commensurate with that required to perform low unskilled jobs or common labor jobs. Reading (extremely weak 1st grade level) writing (not able to form words, but some knowledge of English alphabet and sounds for letters). Verbal and written freedom of expression and communication negligible.

1 Very little understanding of English. Not able to speak English commensurate with common labor jobs. Reading (negligible) writing (no knowledge of the English alphabet or sounds). No ability for freedom of expression or communication in English either verbal or written.

35. GENERAL NINE POINT SCALE FOR PREVOCATIONAL DIAGNOSTIC EVALUATION

9 Knowledge of environment at above average adult cultural level. Up to date on daily current events and news. Shows exceptional ability to care for family both financially (if able to earn living) and as a parent.

8 Knowledge of environment at average adult cultural level. Up to date on daily current events and news. Shows adequate ability to care for family both financially (if able to earn living) and as a parent.

7 Knowledge of environment at below average adult cultural level. Now well informed on most issues covering daily events and news. Shows that he would encounter little difficulty in caring for family both financially (if able to earn a living) and as a parent.

6 knowledge of environment at below average adult cultural level. Weakly informed on most issues covering daily events and news. Shows that he would encounter moderate difficulty in caring for family both financially (if able to earn a living) and as a parent.

5 Knowledge of environment of cultural surroundings considerably below average. Informed only family and close environmental information. Shows he would encounter great difficulty (but be able to accomplish) in caring for his family (if able to earn a living) both financially and as a parent.

4 Shows interest, but is poorly informed in daily environmental and cultural information. Lack stems from cultural continuous lack of interest. Shows that he would encounter great difficulty in handling family budget. Also shows a difficult but able potential of taking parent's role.

3 Shows little interest in being informed of daily environmental and cultural information. As a result this person is poorly informed and shows little initiative to do better. Shows no ability to handle budget (although he would like to) and also shows considerable difficulty in handling parent role. Again this person shows the interest but needs help.

2 No interest in being informed of current events and daily environmental events at any level. Does not accept the responsibility of running a family budget (as result not able) or taking the role of a responsible parent.

1 Only functioning ability of this person is in activities that are pleasing for his own self interest (kidding, women, drinking, etc.). Shows no interest in either caring for or providing for his family through any means. Again this person shows only interest in himself. Family and marriage attract this person only as prestige and grown up, although this responsibility is not accepted.

0

B. Mental Aptitude Status

The following four rating scales were developed by our clinical evaluation consultant. These scores were obtained after the individual had been subjected to testing, this testing being done in groups. It might be noted that the intelligence test was chosen because of our special type of population a bilingual population who, we theorize, would not be fairly evaluated had we chosen a verbal test.

36. INTELLIGENCE (Revised Beta)

The Beta I. Q. was placed on a 9 point rating scale, Number 1 being the lowest I.Q., while Number 9 being the highest I.Q. The minimum I. Q. possible on the test was 28, the maximum I.Q. was 135. Therefore in order to distribute these I.Q.'s along a 9 point scale, I.Q. increments of 11 were employed, the results were as follows:

SCALE	RAW SCORES
9	124-135
8	112-123
7	100-111
6	88-99
5	76-87
4	64-75
3	52-63
2	40-51
1	28-39

37. PERCEPTION (Graham Kendall)

The raw scores were obtained employing the manual's directions. These scores were now placed on a 9 point rating scale, Number 1 being the most pathological, while Number 9 being the least. The maximum raw score possible on the test was 44, while the least was 0. Therefore, every four increments on the raw score was a different point on the 9 point scale which was as follows:

SCALE	RAW SCORES
9	0-4
8	5-9
7	10-14
6	15-19
5	20-24
4	25-29
3	30-24
2	35-39
1	40-44

38. DEXTERITY (Purdue Pegboard)

The raw score was obtained by the directions of the Test. The total score of the client was obtained by summing the right hand, left hand, and both hands. The score was plotted by the percentiles and rating on the 9 point scale. Number 1 rating was the person with least dexterity, while Number 9 was the highest dexterity. The norms were the Industrial Applicants, therefore, the scaling was as follows:

SCALE	RAW SCORE
9	50
8	48-49
7	46-47
6	45
5	43-44
4	41-42
3	39-40
2	37-38
1	34-36

V. EMOTINALITY RATINGS

39. PROJECTIVE (Rorschach)

The Rorschach was rated on a 9 point scale. The total raw score was calculated using the scoring method of M.R. Hanover and M.E. Steiner. On the 9 point scale, a continuum of most pathology (rating of 1), to least pathology, (rating of 9) was employed. The minimum raw score (least pathology) was 30, the maximum raw score (most pathology) was 300. These scores were distributed equally along the 9 point scale, except for the extremes (1 and 9). Because the likelihood of anyone scoring in the extremes (1 and 9) was not great, the extreme score was doubled, that is between 30 and 300 would be 270, and if that was divided by 8, we would arrive at 34, meaning that 34 numbers would be a different point, however, this score was doubled for the extremes, therefore if anyone's raw score was between 234 and 300 they received a rating of 1. After the first rating was obtained, the raw scores were distributed along a 23 point scale in order to complete the 9 point scale.

SCALE	RAW SCORES
9	30-63
8	64-89
7	90-113
6	114-137
5	138-161
4	162-185
3	186-209
2	210-233
1	234-300

VI. Work Attitude Scale (These scales are discussed and identified in Appendix C.)

VII. Attitudes Ratings Toward:

40. Family

This scale provides ratings of the attitudes of the client toward his family. The attitudes rated are the degree of the client's feelings of affection or hostility. (The counselor will most likely be in a better position to rate these attitudes than will the caseworker.)

9 Evidences strong affectionate attitudes toward all family members, attitudes overtly positive.

8 Verbally indicates strong affectionate attitudes toward all family members, but only a small amount of this is evidenced through client's behavior.

7 Rater feels that client has positive feelings toward family but that some evidence exists which indicates there is an interfering factor which prevents there being more affection.

6 There is evidence to indicate there are some interfering factors which depress what is thought to be affectionate feelings toward the family.

5 Neither evidences hostility or affection toward family members.

4 There is evidence to indicate there are some interfering factors which accentuate repressed feelings of hostility.

3 Rater feels that client has negative feelings toward family but that some evidence exists which indicates there is effort on the part of the client to repress hostility.

2 Client verbally indicates negative feelings for family—client acts out these hostile feelings to a small extent.

1 Evidences strong hostile attitudes toward all family members, attitudes overt, behavior so indicates.

41. Government

This scale attempts to rate client's attitudes toward government. In evolving this nine point scale, the degree of positive attitudes toward government were likened to the degree of "good citizenship." The negative attitudes were likened to the degree of dependency on governmental agencies.

9 Daily pursues activities which will remove dependency. Very much aware of other governmental functions and evidences concern for state of country. Active participant in citizenship activities.

8 Evidences guilt feelings for being dependent. Evidences awareness of other governmental functions and does participate to some extent as a citizen (votes, attends meetings, etc.)

7 Evidences feelings of fustration toward being dependent. Evidences desire to participate more as a citizen in governmental functions.

6 Recognizes assistance programs as temporary help measures. Evidences awareness of other governmental functions.

5 Neither seems overtly dependent on government agencies (welfare, etc.) nor seems to evidence active participation in those functions of "good citizenship."

4 A little personal initiative evidenced in his attempts to better his circumstances. Some evidence to indicate his feelings of dependence on governmental agencies.

3 Completely dependent on assistance from governmental agencies. Leaves impression that personal efforts toward self-improvement will be effected only upon becoming aware that assistance will be discontinued.

2 Feels it is his "right" to receive assistance from governmental agencies. Evidence negative, "manipulative" attitude toward government (welfareitis).

1 Does not realistically perceive assistance programs. Blames government in general for his present socio-economic condition. Feels that it is up to welfare agencies to provide him with a living.

42. Education (training)

Definition: attitudes toward self-improvement through training. This scale attempts to rate the extent to which the client feels he can benefit personally and economically from training. It has been assumed that the scale points should vary from a strong positive level to a strong negative level. (The counselor will mostly be in a better position to rate these attitudes than will the caseworker.)

9 Evidences strong desire to participate in a training program.

8 Evidences some desire to participate in a training program.

7 Verbally indicates much desire to participate in a training program, but this is the only evidence of desire.

6 Verbally indicates some desire to participate in a training program, but this is the only evidence of the desire.

5 Verbally indicates a little desire to participate in a training program, but does nothing to make himself available for pursuing the matter.

4 Behavior such that training is not perceived as something of value; the individual's stated goals in life do not include training as a mode of reaching them.

3 Client verbally indicated negative feelings toward participating in a training program, but does state he would like to learn a job while doing it.

2 Evidences some hostility toward training, and seems to have little desire or hope in improving his circumstance through self-adjustment (learning).

1 Evidences strong hostility toward training and seems to have adjusted to the facts of life as he lives them.

DEFINITION:

Evidence: This term includes not only what the client says but how he behaves as well. For example: A client who states he wants to take training and then shows interest by preparing at home for the training evidences a desire.

43. Children's Education

This scale attempts to rate parents' (client and spouse) attitudes toward children's education. In evolving this scale the degree of attitudes were likened to degree of appreciation for education in general and degree of parent participation in programs which are thought to foster children's education. (The caseworker will most likely be in a better position to rate these attitudes than will the counselor.)

9 Expresses and manifests much interest in the children's school work; is concerned about children's grades and general progress in school. Helps children with school work at every opportunity by: 1) motivating them toward higher grade achievement, 2) providing a regular study schedule at home or library, 3) offering praise for good school work and admonishment for unaccepted school work, and 4) consults periodically with school teachers regarding children's school work..

8 Has very good understanding of the importance of education for his children. States explicitly or infers that the family will "sacrifice" so that each child will attain at least a high school education. Has some contact with school authorities regarding children's scholastic standing. Helps children regularly with school assignments.

7 Seems to have an active interest in children's activities, evidences some knowledge of value of education. Some participation in school programs for parents.

6 Evidences some interest in children's educational activities, as well as a little participation in these activities (keeping up with grades, answering teachers' notes, etc.)

5 Neither seems overtly interested in children's education nor against their participation in school programs. Has some awareness of education's value to children.

4 A little personal concern for children having problems in school (induced by caseworker). Some evidence to indicate parent has a little awareness of the value of education to children.

3 Evidences no awareness of education's value to children. Does recognize children legally must stay in school until they are of age.

2 Evidences some hostility toward children having to attend school. Feels that children's time could be better spent at home (or doing what they did when they were children's age).

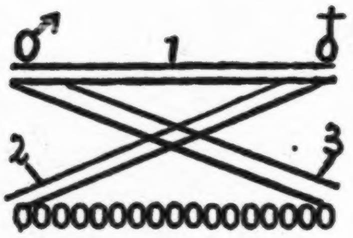
1 Completely uncooperative with school authorities and welfare authorities in regard to keeping children in school (evidences strong hostility toward children having to attend school).

VIII.A. Family Status Ratings

This tentative design now includes a section which is considered to be one of major importance — that having to do with the status of the family. In view of the identification of responsibilities of team members, it seemed logical that the caseworker should be the one to do all the ratings for the various categories. The criteria regarding categories thus far are as follows:

44. Emotional Status (Affection)

The emotional status of a family is defined in terms of the degree of affection and/or hostility various family members have for each other. It is assumed there are three two-way streets involved regarding affection-hostility; the following is a schematic model which will be used to describe the various points on the rating scale:



1. Relationship between husband and wife.
2. Relationship between father and children.
3. Relationship between mother and children.

Definitions of Symbols

♂ - Husband, father

♀ - Wife, mother

000000 - Children

+ - Overt, seemingly honest affection

Z - Some type of interference in relationship

— - Evidenced hostility

44. 9 Highly affectionate family, all relationships overtly positive.

1. + 2. + 3. +

8 Rater feels that all relationships are positive but cannot gather evidence affection is not present.

1. ?+ 2. ?+ 3. ?+

7 Any two of the three two-way streets are positive and the third channel has interference (evidenced interference). The one positive relationship may be overt or inferred.

+(?) +(?) Z

6 Any one of the three two-way streets is positive and the other two channels have interference (evidenced interference). The one positive relationship may be overt or inferred.

Z +(?) ~~Z~~

5 Interference in all three channels. Adequate relationships for family unit to continue.

Z Z Z

4 Any one of the three two-way streets is negative with the other two channels evidencing interference. The negative relationship may be overt or inferred hostility.

Z —(?) Z

3 Any two of the three two-way streets are negative with the other channel evidencing interference. The two negative relationships may be overt or inferred hostility.

—(?) Z —(?)

2 Rater feels that all relationships are negative but cannot gather evidence to indicate overt hostility, hostility is inferred.

1. —(?) 2. —(?) 3. —(?)

1 Overt hostility in all relationships. All channels negative.

1. — 2. — 3. —

DEFINITIONS:

1. **Interference:** Some known factor which interfers with a given relationship — additional persons living within a family unit, financial problems, disabilities of family members, problems in communicating feelings, etc.

2. **Overt:**

   a. Some evidence which can be included in case record to support evaluation

   b. Overt in the case of overt hostility is not to be confused with suppressed hostility. (Suppressed hostility in many instances is considered more debilitating than acting out recognized hostile feelings.) In this case overt means only that recognized evidence is obtainable.

   (For those cases where one of the parents does not reside in the home, then the maximum score obtainable will be six— there is only one two—way street channel to consider.)

B. Family Management of

45. Money and/or Equivalent Management

It is hypothesized that the degree to which clientele and their families manage money (and its equivalent), time, and resources is related to the degree of independence-dependence of the family unit. It is also assumed that management can be scaled in the above three categories with terms like usage and misusage. (To be completed by caseworker)

9 Extensive preplanned usage of money and equivalent at optimum level.

8 Good usage of money and equivalent with some preplanning evidenced.

7 Good usage of money and equivalent with little preplanning evidenced.

6 Adequate usage of money and equivalent but no preplanning evidenced.

5 Usage of money and equivalent such that basic needs are being met because of habit and necessity.

4 Evidence indicated that a few basic needs are not being met due to misuse of money and equivalent.

3 Evidence indicates that some basic needs are not being met due to misuse of money and equivalent.

2 Evidence indicates that most basic needs are not being met due to misuse of money and equivalent.

1 Total misuse of money and equivalent.

Definitions:

Money term includes all cash available to family inclusive of benefits, contributions, wages, proceeds from business enterprise.

Equivalent includes all goods available to family such as clothing, food (surplus commodities), services (child care, clinic, medical supplies) from sources within the family or family friends and relatives, and the community.

46 Time Management

This term includes the family functioning so as to fulfill obligations, do necessary time consumming tasks, etc. It is assumed that by using the terms usage and misuse this category can be scaled. (To be completed by caseworker)

9 Soundly preplanned usage of time so that all daily living needs are met and avocational pursuits are possible.

8 Good usage of time so there is sufficient time to meet daily living needs. Some preplanning evidenced.

7 Good usage of time so there is sufficient time to meet daily living needs. Little preplanning evidenced.

6 Adequate usage of time. No preplanning evidenced.

5 Usage of time is such that basic needs are met. This occurs out of habit and necessity.

4 Evidence indicates that a few basic needs are not being met due to misuse of time.

3 Evidence indicates that some basic needs are being met due to misuse of time.

2 Evidence indicates that most basic needs are not being met due to misuse of time.

1 Total misuse of time.

47. Resources for Avocational Pursuits

Term includes usage, lack of use, and/or misuse of all or any resource available to the family unit and its members within the family constellation (friends and relatives), neighborhood (community centers), playmates, play areas, (to include organizational functions such as Boy Scouts, Girl Scouts, school activities, etc.), church and civic (school) organizations. Avocational includes recreational and educational pursuits which enhance or make for more enjoyable living.

9 Extensive use of resources for avocational pursuits. Much preplanning evidenced.

8 Ample use of resources for avocational pursuits. Some preplanning evidenced.

7 Good usage of resources for avocational pursuits. Little preplanning evidenced.

6 Adequate usage of resources for avocational pursuits. No preplanning evidenced.

5 Usage of resources for avocational pursuits such that routine recreational activities are evident. Family participates in activities out of habit.

4 Some recreational activities of family are evidenced. Some evidence exists to indicate family has misused resources or has not taken advantage of them.

3 Few recreational activities of family are evidenced. Some evidence exists to indicate family has misused resources or has not taken advantage of them.

2 A negligible number of recreational activities of family are evidenced. Much evidence exists to indicate family has misused resources or has not taken advantage of them.

1 No recreational activities of family are evidenced.

C. Health

Three categories are recognized as defining family health—Family Hygiene, Home Sanitation, and Family Illness. Even though it is assumed these categories will most likely be inter-correlated, it is felt that should the circumstance so warrant, having three scales will allow differences in behavior and environment to be documented. (To be completed by caseworker)

48. Family Hygiene

The meaning of this term is analogous to cleanliness and/or sanitary habits the object being to take preventative measures for healthful living. The difference in this rating as compared with II.A. (Personal Hygiene) is that the rater attempts to consider the family as a whole.

9 Evidences the following: clean body and extremities, dental care, clean clothing, good posture, weight control, prudent use of patent medicines (disinfectants, aftershave lotions, skin creams, mouth washes, etc.) and has made adequate use of medical resources.

8 Includes most of the above but omits focusing attention on one or two items—leaves impression client puts forth effort to maintain self at highest level possible.

7 Client leaves impression his daily living habits include some hygienic activities and is motivated or concerned to some extent to live by reasonable health standards.

6 Complies with living (health) standards mostly by habit, evidences a little concern for hygienic self-care.

5 Habitual type of self-care which appears to indicate little understanding of taking preventative measures. Impression is that hygienic habits exist more because of social pressure than for sanitary purposes.

4 Some social awareness of self-care with habits to correlate, but evidences lack of concern for self-care activities.

3 Recognizes something wrong with health, but evidences sloppiness in self-care activities. Evidences a little awareness of social factors related to hygienic habits.

2 Includes most of items in level one but has made some efforts to cover characteristics, detremental.

1 Evidences the following: dirty body and extremities, poor dental care, dirty clothing, poor posture, no weight control, omission or misuse of patent medicines, ignoring medical resources—detremental.

49. Home Sanitation and Liveableness

Term includes the extent to which family develops a liveable, healthful, and adequate housing—(1) space, (2) aesthetic, (3) furniture, (4) appliances, and (5) sanitation constitute criteria. (Sleeping arrangements, etc. included in area and furniture sufficiencies.) (to be completed by caseworker)

9 Optimum home, all five factors adequate for family needs.

8 Adequate home, all factors (except aesthetic) meet family needs. (Little attention given to decoration coordination.)

7 Adequate home, with a few inadequacies noted; basics are present to meet minimum standards of living for all family members.

6 Adequate home, with some inadequacies evidenced; basics are present to meet minimum standards of living for all family members.

5 A few basics are missing and only some of the families' needs are being met. Evidence indicates some poor sanitary habits exist.

4 Basics are present to meet most of the families' needs (heating, amount of furniture, plumbing, cooking appliances, etc.) Many inadequacies are noticed.

3 Some basics are missing and only a few of the families' needs are being met. Many poor sanitary habits exist.

2 Most basics are missing; sanitation such that it jeopardizes health of family members.

1 All basics are missing; detrimental to health.

50. Family Illness

This category includes the concept of rater looking at family unit as a whole and gathering evidence to make an estimate as to the general health of the family unit. Ideally, physical examinations should be obtained on all family members, but since this is not practical or possible, it is thought a rating on the family would be helpful. (If one person in the family has a medical problem, it will be the rater's responsibility to weigh this problem and determine the extent to which it will limit or does not limit the overall family functions.) (to be completed by caseworker)

9 No limitation on activities of family.

8 No limitation on family with medical supervision.

7 Minimum limitation on family without medical supervision.

6 Minimum limitation on family with medical supervision.

5 Moderate limitation on family with or without medical supervision.

4 Moderate limitation on family with medical supervision and possible prospect for improvement.

3 Limited activity of family as defined by medical authority.

2 Minor activity of family as prescribed through medical supervision.

1 Very little or no activity of family as prescribed through medical supervision, needs constant medical attention.

VOCATIONAL REHABILITATION OF DISABLED PUBLIC ASSISTANCE CLIENTS

Selected Demonstration Projects

DATA SHEET #1 - REFERRAL

PART I - Identification

A. Name of Client______________________ VR Case Number________________

PA Case Number________________

B. Residence: County_________; State____________ Referral Date__________

C. Date of Action: Closure from referral_______________ OR: Acceptance_____

Number of Months - Referral to Date of Action_________

PART II - Referral Status Data

A. In the four years prior to the project had the client ever been a referral to the State VR agency? 1. ( ) Yes
2. ( ) No

B. If yes in Item IIA, disposition of case   Year
1. ( ) Closed from referral________
2. ( ) Closed not rehab'd. ________
3. ( ) Closed rehabilitated ________

At time of coming into the project, client was:
4. ( ) In the VR referral load
5. ( ) In the VR active caseload

C. Disabling condition(s) (describe)
1. Major disabling condition

_________________ Detailed
VRA
_________________ code_____

2. Secondary disabling doncition

_________________ Detailed
VRA
_________________ code_____

D. Age at referral_________

E. Sex 1. ( ) Male 2. ( ) Female

F. Race

1. ( ) White   4. ( ) Latin Amer.
2. ( ) Negro   5. ( ) Other
3. ( ) Am. Indian 6. ( ) Not Avail.

G. Highest grade in school completed_____

H. Major occupation in last 5 years

___________________code________

I. Type of public assistance received by client
1. ( ) None
2. ( ) General assistance only
Federally-aided PA with or without GA supplementation:
3. ( ) AFDC   6. ( ) OAA
4. ( ) APTD   7. ( ) MAA only
5. ( ) AB   8. ( ) Other

J. Type(s) of PA received by members of the family not included in client's assistance payment:
1. ( ) None
2. ( ) General assistance
Federally-aided PA with or without GA supplementation:
3. ( ) AFDC only. 6. ( ) OAA only
4. ( ) APTD only 7. ( ) MAA only
5. ( ) AB only   8. ( ) 2 or more types

K. No. months from client's most recent opening for PA to referral__________

L. Had client received public assistance prior to date of most recent PA opening?
1. ( ) Yes 2. ( ) No. 3. ( ) not avail.

M. Was client in a Community Work and Training program at referral?
1. ( ) Yes 2. ( ) No

N. Weeks worked in last 12 months
1. ( ) part time __________
2. ( ) full time __________

O. Number of years since last employed Full-time:
1. ( ) Less than one year
2. ( ) One year but under three
3. ( ) Three years but under five
4. ( ) Five years or more
5. ( ) Never

P. Number of VR interviews during referral status with:

1. Client ____________
2. Family ____________
3. Employer(s) ____________
4. Other placement resources ____________

Q. VR services provided in evaluating client's potential:

	With cost to VR	No cost to VR
1. By rehabilitation or adjustment centers........	$____________	( )
2. By Workshops	$____________	( )
3. By other sources	$____________	( )

R. Did the client receive psychological evaluation while in referred status?
1. ( ) Yes 2. ( ) No

S. Action Taken:
1. ( ) ACCEPTED FOR SERVICES
OR
CLOSED,
2. ( ) Little or no functional capacity for work
3. ( ) Combination if disability, functional illiteracy, lack of skill
4. ( ) Disability not substantially handicapping
5. ( ) Services not needed
6. ( ) Inability to place
7. ( ) Facilities or services not available
8. ( ) Entered institution
9. ( ) Left area
10. ( ) Unable to locate
11. ( ) Death
12. ( ) Secured employment
13. ( ) Declined services
14. ( ) Feels too disabled
15. ( ) Social and/or family problems
16. ( ) Fear of financial loss
17. ( ) Other ______________________________
(specify)

Remarks: ____

____

______________________________ Authorization signature (PA) Date

______________________________ Authorization signature (VR) Date

VOCATIONAL REHABILITATION OF DISABLED PUBLIC ASSISTANCE CLIENTS

Selected Demonstration Projects

DATA SHEET #2 - ACCEPTED STATUS

Name of Client ______________________

VR Case Number ______________

PA Case Number ______________

Residence: County ______________________

State ____________________

Date Accepted __________ Date Closed __________ Mos. From Accept. to Clos. ___

Part III

A. Size of family (client and relatives living at home) at closure

	Enter number
(1) Client-------------------	____
(2) Spouse of client (0 or 1)	____
(3) Children of client (Under 18)	____
(4) Other dependents of client	____
(5) Other Relatives----------	____
(6) Total in family:(1) thru (5)	____

B. Amount of monthly public assistance payment received by client, to nearest dollar:

(1) At acceptance----- $________

(2) At closure $________

C. Amount of monthly public assistance payment received by members of the family not included in client's assistance payment, to nearest dollar

(1) At acceptance----- $________

(2) At closure $________

D. Weekly earnings of client, to nearest dollar:

(1) At acceptance----- $________

(2) At closure $________

E. Other sources of income of the client and his family at closure: (Circle appropriate codes)

	Value code
(1) Earnings of other family members ---	1
(2) OASDI benefits ---	2
(3) Other benefits or pensions ---------	4
(4) Other __________ (specify)	8

(5) Sum of circled codes ______

F. Work status of client

	At Acceptance	At Closure
(1) Wage or salaried worker: Competitive labor market	( )	( )
(2) Wage or salaried worker: Sheltered workshop-----	( )	( )
(3) Self-employed (except BEP)	( )	( )
(4) BEP (State-agency managed business enterprise) ---	( )	( )
(5) Homemaker (own home) ---	( )	( )
(6) Unpaid family worker ---	( )	( )
(7) Student------------------	( )	( )
(8) Other--------------------	( )	( )

G. Job participation

	At Acceptance	At Closure
(1) Working full-time	( )	( )
(2) Working part-time	( )	( )
(3) Not working	( )	( )

H. Job or occupation at closure:

______ __________ code __________
(specify)

I. Number of PA casework interviews with client or family:

(1) 2-6 months before referral ____

(2) Under 2 months before referral ____

(3) During project ____

J. Social services provided by the public welfare agency: (circle appropriate codes)	Within 2 months prior to referral	During project	Planned to continue in future	Sum of Codes
(1) Educational or vocational trng.	1	2	4	
(2) Health Care	1	2	4	
(3) Improved financial functioning	1	2	4	
(4) Maintaining family life and improving family functioning	1	2	4	
(5) Maintaining home	1	2	4	
(6) Protection of children	1	2	4	
(7) Protective service for adult	1	2	4	
(8) Returning persons to home or community from institution care	1	2	4	
(9) Self-care services	1	2	4	
(10) Maintaining or improving social relationships and participation in community life	1	2	4	
(11) Self-support services	1	2	4	

K. No. of interviews (in active status) with:

(1) Client ------ ____________

(2) Family ------ ____________

(3) Employer(s) ____________

(4) Other placement resources----- ____________

L. Did the client receive psychological evaluation while in accepted status?

(1) Yes ( ) (2) No ( )

M. Source, type and cost of case services provided client from referral to VR closure, to nearest dollar:	With cost to VR agency	With cost to PA agency	No cost to VR or PA agency
(1) By rehabilitation or adjustment centers (totals)	$____	$____	( )
(2) By workshops (total)	$____	$____	( )
(3) By other sources:			
a. Diagnostic procedures	$____	$____	( )
b. Surgery and treatment	$____	$____	( )
c. Prosthetic appliances	$____	$____	( )
d. Hospitalization and convalescent care (other than for diagnosis)	$____	$____	( )
e. Training and training materials	$____	$____	( )
f. Maintenance and transportation	$____	$____	( )
g. Tools, equipment and licenses	$____	$____	( )
h. Other ____________ (specify)	$____	$____	( )
i. TOTAL (a. through h.)	$____	$____	XXX

N. Reason for CASES CLOSED NOT REHABILITATED

1. ( ) Little or no functional capacity for work
2. ( ) Combination of disability, functional illiteracy, lack of skill
3. ( ) Disability not substantially handicapping.
4. ( ) Services not needed
5. ( ) Inability to place
6. ( ) Facilities or services not available
7. ( ) Entered institution
8. ( ) Left area
9. ( ) Unable to locate
10. ( ) Death
11. ( ) Secured employment
12. ( ) Declined services
13. ( ) Feels too disabled
14. ( ) Inability to arrange child care
15. ( ) Social and/or family problems
16. ( ) Fear of financial loss
17. ( ) Condition deteriorates
18. ( ) Other ____________ (specify)

____
Authorized Signature (PA) Date

____
Authorized Signature (VR) Date

APPENDIX

B

PREVOCATIONAL CURRICULUM

PAGE

Curriculum Outline 120

Syllabus of Instruction 121

CURRICULUM

The curriculum for Pre-vocational Diagnostic Evaluation is set out in two parts. These consist of the Curriculum Outline and the Syllabus of Instruction.

I. CURRICULUM OUTLINE

A. CIVIC PARTICIPATION KNOWLEDGE

B. ECONOMICS--MONEY MANAGEMENT

C. SELF-CONCEPT

D. SOCIAL KNOWLEDGE: PERSONAL-INTERPERSONAL

E. ACADEMIC SKILL EVALUATION

  1. Speaking English
  2. Reading
  3. Writing
  4. Grammar
  5. Arithmetic

F. JOB APPLICATIONS

G. INITIAL INTERVIEW FOR WORK

II. SYLLABUS OF INSTRUCTIONS

A. CIVIC PARTICIPATION KNOWLEDGE

1. Objectives. The successful student will be able to:

   a. Explain the concept of democratic government as used in the United States of America.

   b. Label a chart (worksheet) showing the general organization of the Federal Government.

   c. Label a chart (worksheet) showing the general organization and function of the State Government.

   d. Label a chart (worksheet) showing the general offices and functions of Bexar County.

   e. Label a chart (worksheet) showing the major offices and functions of San Antonio City Administration.

   f. Explain how one can and should participate at every level of government to help carry out civic responsibility.

   g. Describe how the government is supported at local, state and national levels. Explain how one can contribute to this support.

   h. Explain the significance of individual independence to individual freedom.

   i. Name the agencies in our local area that will help one find employment.

   j. Name some agencies that will give other assistance until one can become completely independent. Explain why the assistance should be temporary (except in cases of total disability).

   k. Review the many ways one can demonstrate civic participation.

B. ECONOMICS--MONEY MANAGEMENT

1. Objectives. The successful student will be able to:

   a. Explain each word on a list of words commonly used in discussing money management.

   b. Explain why a person with a smaller than average income needs to spend as much or more time on plans for spending money.

c. Explain the advantages vs disadvantages of a checking account and how to manage an account.

d. Describe a good savings program and tell whether one is necessary for him or her.

e. Explain the need for life insurance, who should have the main coverage, and what kind to buy.

f. Explain how one should divide expenditures for:

   (1) Food

   (2) Insurance

   (3) Shelter and household items

   (4) Clothing

   (5) Transportation

   (6) Health and recreation

   (7) Other

g. Explain how to divide the food dollar.

h. Explain how to get the most for one's money in food buying.

i. Explain how to plan and get the most for the shelter and household dollar.

j. Explain how to get the most for one's clothing dollar.

k. Explain how to divide and use one's health and recreation dollar to the best advantage.

l. List some circumstances where it might be wise to use credit.

m. List some dangers in credit buying.

n. List some questions that one should ask himself or herself before using credit.

o. Explain the importance of understanding the credit contract and list what should be clearly stated on the contract.

p. Explain the extra expense (interest—service charge) connected with credit buying.

q. Plan a budget for a family including husband, wife and five children, ages 3-12, who receives $250 per month, rents a $35 per-month house, and lives ten blocks from work.

r. Plan a budget for a family of one adult and three children, ages 7-14, where the parent receives $160 per month, rents a $32 per-month house, and lives five miles from work near a bus line.

s. Make a list of things that he or she needs to spend money for now or very soon.

t. Make a list of things that he or she wants to buy in the future.

u. Plan a budget for his or her family.

C. SELF-CONCEPT

1. Objectives. The successful student will be able to:

a. List the (basic) things that one is forced to do in order to live.

b. Make a list of additional things or ways that people in our society:

(1) Have learned to do in order to fulfill basic needs.

(2) React to social, including governmental, forces.

(3) Feel about getting what they need.

(4) Need to feel satisfied.

c. Explain how a person can develop confidence, pride and satisfaction from the knowledge of doing what is proper in our society.

d. Describe how people may act when faced with a serious obstacle.

e. Explain why some ways of meeting problems are better than others.

f. Interpret the statement, "Most people can do somethings well—all can improve in some respect."

g. List ways in which our society helps those who are in good standing but who are temporarily in need of assistance.

h. List ways that all individuals, particularily those who know the value of assistance, can help our society and make it stronger.

i. Explain how some people with a handicap have become truly strong (such people as Glen Cunningham and others can serve as examples).

j. Explain how an individual may develop strength, confidence, self-respect, and the respect of others through purposeful determination.

D. SOCIAL KNOWLEDGE: PERSONAL-INTERPERSONAL

1. Objectives. The successful student will be able to:

a. Explain how good self-care and good personal appearance improve a person's position in life.

b. Make a list of the things that are important in self-care and good personal appearance, describe the benefits, and decide which things he or she should concentrate on most.

c. Describe the kind of person that most people like and point out the main area or areas that he or she is improving to become more like this kind of person.

d. Make a confidential list of members of the class ranked in the order of being most like his or her ideal person "that most people like." (The instructor may collect these to construct a sociogram at this point in the class. Later, prior to the end of the evaluational classes, another set of lists and sociogram will show what changes have occurred. Class members can be told that they will be given some results at the end of the course—most socially improved person(s) according to the sociograms.)

e. Make a list of officials of government (including police officers etc.), professional people, business people, and others ranked in the order of being most respected. (The instructor may collect these rating sheets and construct a sociogram for the basis of discussion.)

f. Discuss the reasons why some important people in our society get very little credit, appreciation, or respect for what they do. (Use sociogram from (5) above as a basis of critique.)

g. Discuss the relationship of respect and cooperation in dealing with people.

h. Participate as an observer, judge our principal character in guided demonstrations in degrees of cooperativeness by "role playing." (Instructor and lead student may begin by demonstrating some civic task. Others may follow using pre-arranged guide sheets for roles. Class may critize.)

i. Discuss the relationship of cooperation and team work on a job.

j. Explain the statement, "True team work requires some sacrifice at times from members to make the team strong."

k. Participate as an observer, judge our principal character in guided "role playing" demonstrations of team work to maximize effort. (Each demonstration may be critized for general effect.)

l. Explain how each individual should be a responsible member of many teams. Give some of the main responsibilities required as a team member of:

(1) The crew on the job
(2) The family at home
(3) The community on the street
(4) The state on the highways
(5) The nation at the polls

E. ACADEMIC SKILL EVALUATION (grades 1-7)

1. Speaking English

a. Alphabet
(1) Objectives. The successful student will be able to:
(a) Recognize letters of the alphabet by pronouncing each letter properly when shown on a card.

(b) Recognize and pronounce letters from printed words.

b. Phonetics
(1) Objectives. The successful student will be able to:
(a) Recognize vowels when shown on cards and vocalize sounds.

(b) Recognize consonants when shown on cards and vocalize sounds.

(c) Verbalize common consonant blends.

(d) Use phonetic sounds to verbalize words.

2. Reading. (The programmed texts for reading, grades 1-7, which are being prepared for the Job Corps may be used when available.)

a. Objectives. The successful student will be able to:
(1) Establish the initial reading comprehension level by "reading comprehension test" progressively ranging from grades 1-7.

(2) Learn common key words at the appropriate grade level to the extend of being able to recognize, pronounce and explain them.

(3) Practice reading in appropriate grade level materials.

(4) Master common key words of each progressively higher grade level up to grade seven.

(5) Practice reading in each higher grade level after satisfactorily passing the reading comprehension test at the lower level and after mastering common key words for the new grade level.

3. Writing

a. Objectives. The successful student will be able to:

(1) Review the letters of the alphabet by recognizing both capital and small letters from flash cards.

(2) Print alphabet in both small and capital letters in sequence.

(3) Practice printing common simple words and progress through common key words for the appropriate grade level.

(4) Recognize longhand letters by identifying capital and small letters on flash cards.

(5) Practice longhand by writing simple words and key words for the currently appropriate grade level..

(6) After satisfactory completion of a lower level, practice longhand by writing key words for the next progressively higher grade level to grade seven.

4. Grammar

a. Objectives. The successful student will be able to:

(1) Define a sentence.

(2) Explain the difference in "content words" and "structure words."

(3) Explain and identify the subject and predicate of sentences.

(4) Define and recognize nouns and verbs in sentences.

(5) Define and recognize pronouns in sentences.

(6) Define and recognize proper nouns in sentences.

(7) Define regular verbs and recognize the three tenses in sentences.

(8) Recognize selected irregular verbs in the present, past, and past participle tenses.

(9) Define and recognize adjectives and adverbs in sentences.

(10) Define and recognize simple, complex, and compound sentences.

(11) Formulate simple sentences from scrambled words.

(12) Write simple sentences about given topics.

(13) Write complex and compound sentences about given topics.

(14) Define the characteristics of a good paragraph.

(15) Formulate a paragraph from scrambled sentences.

(16) Practice writing paragraphs about given topics.

(17) Write several practice letters.

(18) Write a letter to the counselor requesting an appointment for the week following classes.

5. Arithmetic

a. Objectives. The successful student will be able to:

(1) Demonstrate current functional knowledge of arithmetic by successful accomplishment of as many criterion test for grades 1-7 as possible.

(2) Beginning at the level of need, accomplish successive programmed texts covering the following operations:

(a) Addition and subtraction, unites 1-13

(b) Multiplication and division, books 1-10

(c) Fractions: basic concepts, units 1-12

(d) Decimal numbers, units 1-13

(3) Work selected--practical household problems

(4) Work selected--work-a-day problems

F. JOB APPLICATIONS

1. Objectives. The successful student will be able to:

a. Describe how to find the right person for job inquiry.

b. Explain how the completion of the job application form may be a type of test for the hopeful worker.

c. Explain why completeness is important in filling out the application form.

d. Give current personal data on a worksheet.

e. Explain the importance of specifying the job he or she wants.

f. Give information concerning your family on a worksheet.

g. Give educational and training background on a worksheet.

h. Give work history on a worksheet.

i. Give history of military service and police history if any on worksheet.

j. Give physical information on the worksheet.

k. Give references on the worksheet.

l. Analyze several sample applications in group discussion.

m. Complete a personal "composite application form" to use as a guide for making actual job applications.

n. Make modifications to the guide if necessary with the advice of the instructor.

G. INITIAL INTERVIEW FOR WORK

1. Objectives. The successful student will be able to:

   a. Review the importance of personal appearance.

   b. Discuss the possibility of the initial interview before or after the completion of the job application form.

   c. List some of the main things that the interviewer will be interested in and those things he will try to determine specifically.

   d. Explain how developing a friendly attitude can help make one feel at ease.

   e. Explain the importance of being confident, eager, and sincere.

   f. Explain the importance of prompt, brief, and well-organized statements.

   g. Identify personal interests that will benefit the firm. (Prior to this class period prepare the client's ratings, progress evaluations, comments, etc. for the counselor-caseworker conference to help initiate a vocational plan.

   h. Explain how to follow the interviewer's lead in giving information and how to counter lead into areas of strength.

   i. Discuss information that the potential employee should ask for.

   j. Explain how to summarize his or her vocational needs in concluding the employment interview.

   k. Criticize an employer-applicant interview either from a tape recording or actual role playing.

   l. Practice interviews with someone playing the role of the personnel manager.

APPENDIX

C

SUPPORTING RESEARCH INFORMATION

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Analysis of Work Attitude Scales

In its original form, the 250 items of the WAS were intended to appraise worker attitudes, motives, perceptions, and adjustment in the 20 areas shown in Table I . It was administered in its original version to the 113 clients, data for whom are the subject of this Report. From experience gained in using the WAS with this clientele, it soon appeared desirable to shorten the device, if possible; to revise the language of both the English and Spanish versions; and to undertake psychometric experiments designed to determine, empirically, the major work attitude factors being measured by the instrument. It may be recalled that a chief objective of studies designed to determine the factors being assessed by a series of test scores or other measures (such as numerical ratings of a client's characteristics) is to arrive at an economical and empirically justifiable set of variables. These can then be used, not only in the clinical assessment of a client prior to efforts at his rehabilitation, but, in research, as potential "predictors" of criteria reflecting each client's relative "success" vs. "failure" in becoming rehabilitated.

Several kinds of work have been done in our efforts to achieve useful factor-variable scales for the WAS. First of all, each of the 250 constituent items was printed on a separate card; several decks of 250 item-cards were then assembled. These decks of 250 item-cards were each divided into 2 subdecks, item-cards 1-125 and 126-250, respectively. Sixteen judges were used to sort items 1-125, independently, into the categories of attitude shown in Table II; 26 judges were employed to sort items 126-250 in the same way. Judges were graduate students in psychology or educational psychology at The University of Texas.

After judges had sorted the 250 WAS items into 20 construct categories, an examination was made of these item classifications. Items which had been grouped by 1/3 or more of the judges into a single construct category more often than into any other of the 20 available categories were selected to represent that category. One hundred twenty of the 250 WAS items survived this initial screening; they represented (with 4 or more items each) 13 of the original 20 construct-variables theoretically being measured by the original form of the WAS, as shown in Table II, and renamed slightly from the original constructs on the basis of item content.

Responses to the WAS had been filled in by (or for) 103 of the 113 clients involved in the Project to that date. Each of these 103 WAS protocols was scored according to the 13 provisional, judgmentally-derived scoring keys just described. All possible correlation coefficients among these 13 scales were then computed in order to assess, in a preliminary way, the degree of association (or independence) of each of the 13 scales from its fellows. These intercorrelations are shown in Table III.

Of the 66 inter-scale correlations shown in Table III, 40 are statistically higher than chance alone would permit, and, thus, can be taken to mean that a good deal of real "overlap" exists in what these apparently different scales measure for these clients. Such overlapping might mean that the judges were unable to sort the items with high discrimination or, perhaps, that the clients themselved do not have such highly differentiated "work attitudes" as our multiplicity (13) of attitude constructs would suggest. This matter will be further commented on below when the factor-analytic examination of these intercorrelations is presented.

At this juncture, attention should be directed to the data presented in Table III (Body), i.e., the possible range of raw scores, the obtained raw score means and standard deviations for these 103 clients, and the split-half (Spearman-Brown corrected) reliability estimates for each of the 13 WAS scales. On the basis of these statistics, it seems apparent that scales 3,4,5,6,7,9, 11 and 12 are probably sufficiently discriminating for use in comparing the means of client groups (e.g., "more successful" vs. "less successful"). Scales 5 and 9 should probably never be used for individual diagnosis with such clients as these. Scales 4, 6, 11, and 12 should be used in individual diagnosis, or prediction, only with extreme caution and full recognition that such use will lead to errors of judgment in from 1/3 to 1/4 of all individual cases. The data summarized in Table IV, from Thorndike and Hagen (1961) indicate why this is true.

TABLE 14

THEORETICAL CONSTRUCTS UNDERLYING WAS

(1) Work Concepts
(2) Work Habits
(3) Authority Relationships
(4) Interpersonal Relationships
(5) Personal Philosophy
    (a) Generally Optimistic
    (b) Generally Pessimistic
(6) Self Concept
(7) Personal Characteristics or Idiosyncrasies
    (a) Somatic or Hypo-chondriacal preoccupations
    (b) Paranoid tendencies
(8) Dependency and Independent Leanings
(9) Flexibility vs. Rigidity of Behavior
(10) Perseverance and Tolerance Level
(11) Feelings of Personal Dignity
(12) Emotional Responsiveness
    (a) Overreactive
    (b) Sponge (apathetic)
    (c) Special E.
(13) Leisure Time Activities
(14) Family Relationships
(15) Identification with Social, Cultural, Work Groups
(16) Political Attitudes
    (a) Gov. Control and Welfare Programs
(17) Special Prejudices
    (a) racial
    (b) religious
    (c) Ethnic
    (d) Foreign va U.S. Labor standards
    (e) Union vs. non-Union
(18) Personal Aspirations and Status Needs
(19) Ability to withstand ambiguity
(20) Attitude toward practical problems, responsibility vs. unrealistic or no attempt to resolve.

TABLE 15

JUDGEMENTALLY DERIVED WAS SCORING KEYS

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Score	Item No.	Content
CONSTRUCT 1		COMMITMENT TO WORK
F	3	Jobs never seem very certain.
F	15	Money is about the only thing you can expect in in return for your work.
T	19	Any kind of honest labor is honorable.
T	35	Extra money should be given to those who do the best work.
F	45	Good jobs are really hard to find.
T	63	Work is that which makes humans different from animals.
F	73	All jobs are alike, they make people tired.
F	100	A person cannot do any job if he is not trained.
F	137	People who have desk jobs are happier than those who do not.
T	151	People work because they want and not because they have to.
F	161	People do not really work unless they use their hands.
F	171	People who work inside live longer than those who work outside.
F	183	Only those people who work with their hands actually do any work.
T	184	There is not enjoyment in living unless one does some kind of work.
F	201	An employee should not be asked to work overtime except in unusual cases.
CONSTRUCT 2		GOOD vs. POOR WORK HABITS
T	126	A worker should not talk about himself while at work.
T	159	People like to work on Friday better than they do on Monday.
T	176	When things are slow at the job, an employee should look around for something to do rather than goof off or just rest.
T	203	Most employees waste too much time while on the job.
F	222	If a person does not have much to do, he should stretch his work out to make it last longer.

Table 15 continued

CONSTRUCT 3 GOOD *vs*. POOR ATTITUDES TOWARD EMPLOYERS

Score	Item No.	Content
F	6	Bosses tend to upset a person.
F	8	If a person does not do his work just right, I feel the boss would say something.
F	53	If you do your work rapidly, you are likely to be given more work because the boss will take advantage of you.
T	66	A person dislikes having anyone tell him how to do his job.
T	68	A person is willing to be told how to do his job.
F	116	Employers are only interested in the amount of money their employees can earn for them.
F	120	Employers expect you to work too fast.
T	122	Employees should only be interested in satisfying the wishes of the boss.
F	139	If a person is liked by his boss, he does not have to do much work.
T	163	If a person does good work, his boss will like him.
F	167	Most bosses are like policemen.
F	196	Most employers want to work me too hard.
F	197	Most bosses are too strict with their employees.
F	199	People seem to take advantage of their employer.
F	200	On most jobs, I felt the boss wanted me to do too many things at the same time.
T	205	Most people pretend to be working very hard when the boss is around.
F	207	Employers are not concerned enough about their workers' problems.
F	215	Most employers are nosey about people's personal problems.
F	221	Employers should brag on their people more.
F	223	It seems like employers are always looking for someone to bawl out.
F	227	The way to get ahead on a job is to be buddy-buddy with the boss.
T	230	If you do not know something you need to know, you should ask the boss.

Table 15 continued

Score	Item No.	Content
	CONSTRUCT 4	GOOD *vs*. POOR INTERPERSONAL ATTITUDES
F	70	A person does not like other workers telling him how to do his job.
F	86	If a person cannot get along with other people on the job, then the best thing for him to do is quit.
T	109	Fellow workers have a way of finding out about a person's problems.
T	128	It is just as important to get along with your fellow workers as it is to do a good job.
F	131	Other workers do not like to help you with your work.
T	140	I am not usually annoyed by other workers.
F	145	People should let others do what they want to and not boss them around.
F	153	Most people do not accept others for what they are.
T	225	Employees as a rule get along nicely together.
T	226	If a fellow employee is behind in his work, a person should try to help him catch up.
T	232	A person should be willing to accept suggestions from others.
	CONSTRUCT 5	HOPEFULNESS *vs*. HOPELESSNESS
F	28	There is little a person can do.
F	47	Most people are unhappy with their jobs.
F	52	A person usually feels he will not get the job for which he applies.
T	77	Hoping for better days to come is what makes people want to go on living.
T	79	If there is not opportunity to earn a living, then this makes life hopeless.
F	105	People who cannot afford children are usually the ones who have them.
F	124	People work because they have to and not because they want to.
T	211	Most people act like the world owes them a living.
T	241	Everyone can better help themselves if they try.
T	244	It is not what a person was in the past that is so important, it is what he is now and what he is trying to do.
F	250	An uneducated person can never get ahead.

Table 15 continued

CONSTRUCT 6 FAVORABLE vs. UNFAVORABLE SELF-CONCEPT

Score	Item No.	Content
T	14	I am very particular about my work.
T	20	There is nothing I feel I cannot do.
F	78	I seem to be overly sensitive to any kind of kidding.
F	110	I cannot do things as other people can.
F	114	Most people seem to like my work.
F	119	I do not have enough self-confidence to work.
F	121	There are so many people who can do a job better than I can.
F	123	I usually feel someone will not like my work.
F	150	I believe I should have special favors at the job because of my high qualifications.
T	206	I can remember from one day to the next what I have been told or shown how to do.
T	224	Most employers do not doubt my abilities.
T	245	I feel I can always learn how to do something new if I really try.
	CONSTRUCT 7	GOOD vs. POOR SELF-ADJUSTMENT
F	97	Illness causes a person to think differently.
F	106	There is usually somebody on a job that will have it in for a person.
F	132	I'm too sick to work.
F	134	I usually get all the dirty work to do on a job.
F	142	My physical health does not allow me to work.
F	148	It seems like most people are against a person where he works.
F	156	A person who has suffered so much and has had so many problems should not be expected to work.
F	158	For some reason people treat a person unkindly and make fun of him.
F	164	The job on which I work will have to be easy because of my physical health.
F	218	Other people try to get ahead of me on jobs.
F	219	Most people try to get ahead of me on jobs.
F	234	A lot of people seem to enjoy making a person feel bad.

Table 15 continued

Score	Item No.	Content
	CONSTRUCT 8	AUTONOMOUS *vs*. DEPENDENT ATTITUDE
T	18	I would rather get my own job than to have someone else get it for me.
T	90	I feel I should have my freedom in doing my work the way I think it should be done.
T	143	People should solve their own problems and not get others' advice about them.
T	155	Other workers like for you to help them with their work.
F	228	If you do not like the way a fellow employee treats you, you should tell the boss.
	CONSTRUCT 9	FLEXIBLE *vs*. RIGID ORIENTATION
F	38	I like things the way they are.
F	54	A person insists on doing the work the way he wants to do it.
F	136	I cannot learn to do new things at my age.
F	160	I can't stand to work indoors.
F	210	I get tired of doing the same job day in and day out.
	CONSTRUCT 10	FAVORABLE FAMILY ATTITUDE TO WORK
T	67	If a husband or wife works hard, his or her spouse appreciates it.
T	170	A person's family does not want him to work at some types of jobs.
F	178	It is more important for a person to stay home with his family than to work for the wages he usually receives.
F	194	My family has done better than I have.
F	242	If I work all day I am too tired to pay enough attention to my wife (husband) and children.

Table 15 continued

Score	Item No.	Content
	CONSTRUCT 11	DEPENDENCE ON vs. INDEPENDENCE FROM GOVERNMENT AND WELFARE SUPPORT
T	27	The government should see to it that they take care of the people.
T	57	It is nice to know that if you do not work the government will take care of you.
T	59	Welfare will give you more money than you could earn if you worked.
T	81	If the government could only understand people's problems, it could better help them.
T	91	Government should make employers quit using machines so there will be more jobs for people.
T	220	My circumstances are such that I feel justified in taking advantage of government and state services and assistance.
T	248	The government should pay higher disability allotments (claims) so that a handicapped person would not have to work.
	CONSTRUCT 12	LACK vs. HOLDING OF SPECIAL PREJUDICES
F	83	It is sometimes difficult to believe that the church is more interested in its people than it is in their donations.
F	149	People who go to church make the best workers.
F	165	People who do not go to church find it hard to get along with others at work.
F	185	People who drink do poor work.
	CONSTRUCT 13	AMBITION vs. LACK OF AMBITION
T	48	I want to get rich when I work.
F	146	I have enough money so that I do not have to work.
F	186	I don't think I should work unless I get good wages.
T	214	I do not believe I should stay on a job for over six months without receiving a raise.
F	216	There is a future in working for a small company.
T	249	I believe I should never give up trying to better myself vocationally.

Table 16

INTERCORRELATIONS* AMONG 13 WAS SCALES FOR 103 WELFARE-REHABILITATION CLIENTS

Construct Variable No.	1	2	3	4	5	6	7	8	9	10	11	12	13
2	.18	—	.11	.24	.10	.26	.00	.22	.11	.28	.06	.04	.23
3			—	.52	.53	.58	.73	-.07	.63	.39	-.47	.29	.07
4				—	.39	.55	.31	.09	.40	.32	-.16	.27	.29
5					—	.50	.42	.04	.43	.45	-.21	.21	.09
6						—	.53	.06	.43	.44	-.09	.27	.26
7							—	-.13	.54	.29	-.38	.30	-.04
8								—	-.19	.14	.26	-.08	.15
9									—	.33	-.35	.42	.13
10										—	.00	.16	.41
11											—	-.13	.07
12												—	.11
13													—

*If $r = .195$, $P < .05$; If $r = .250$, $P < .01$

TABLE 17

PER CENT OF TIMES THE DIRECTION OF A DIFFERENCE WILL BE REVERSED IN A REPEAT TESTING FOR SCORES AT
50th and 75th PERCENTILES
(of., THORNDIKE AND HAGEN, 1961)

	PER CENT OF REVERSALS IN REPEATED TEST		
RELIABILITY COEFFICIENT	SCORES OF INDIVIDUALS	MEAN SCORE FOR N=25	MEAN SCORE FOR N=100
.00	50%	50%	50%
.40	40%	11%	0.7%
.50	37%	5%	0.04%
.60	33%	1%	---
.70	27%	0.1%	---
.80	20%	—	---

EXAMPLE OF CONCEPTS OF CORRELATION AND FACTOR

Suppose that we have given tests of (a) vocabulary, (b) reading comprehension, (c) verbal fluency, and (d) manual dexterity to each of 5 clients—Alfie, Bertie, Charlie, Connie, and Eddie. Their scores are shown in Table II, below.

TABLE 18

Scores on Tests of Vocabulary, Verbal Fluency,
Reading Comprehension, and Manual Dexterity
Obtained by 5 Clients

Client	Vocab.	Fluency	Comprehension	Dexterity
Alfie	82	35	53	47
Bertie	76	34	49	50
Charlie	64	33	45	63
Connie	51	32	41	72
Eddie	49	31	40	80

Inspection of Table V (above) shows that Alfie got the highest score of all 5 clients on Vocabulary, Fluency, and Comprehension, but was the lowest on Dexterity. Eddie, however, was lowest of all 5 clients on Vocabulary, Fluency, and Comprehension, but was highest among all 5 clients in Dexterity. Notice, too, that Alfie, Bertie, Charlie, Donnie, and Eddie ranked 1, 2, 3, 4, 5 (in that order) on three of the 4 tests — Vocabulary, Fluency, and Comprehension. That is to say, any one of the 3 tests ranked the 5 men in exactly the same way— in other words any one of the 3 tests gave exactly the same information as any other one of the 3 tests. The fact that the numerical scores on the 3 tests differ in magnitude is really irrelevant.

Now, the fact that the 3 tests do indeed rank 5 men in the same order means that these 3 tests are perfectly and positively correlated.

A *perfect positive* correlation is expressed as r= +1.00. So,

Vocabulary and Fluency: r = +1.00

Vocabulary and Comprehension: r = +1.00

Fluency and Comprehension: r = +1.00

Does it not seem likely, then, that all 3 of these tests are measuring aspects of a *common underlying* (or *more basic*) *factor* -- say *verbal facility*, maybe?

Notice that the Dexterity test ranks the 5 men in *exactly the reverse of the order* in which they are ranked by any of the 3 *verbal facility* tests. This means, then, that Dexterity correlates perfectly negatively with the verbal tests, i.e., r = -1.00.

Correlation coefficients (r) may have values anywhere from:

r = 0.00 - r = +1.00 *and*

r = 0.00 - r = -1.00

Height and weight in men correlate about r = +.50 meaning that there is a tendency for taller men to be heavier, but by no means is there a perfect positive correlation. One would think, however, that height *and* weight are both reflections of a *more basic common factor-variable*, perhaps "body size."

TABLE 19

FACTOR ANALYSIS OF 10 DEF SCALES

(N = 113)

DEF VARIABLE % VAR.	FACTORS I 44.59	 II 22.40
1. Personal Hygiene	.06	.92
2. Clothing	.14	.86
3. Aesthetic	.19	.77
4. Oral Hygiene	-.06	.23
5. Money & Equivalent Management	.92	-.01
6. Time Management	.92	.02
7. Resources Management	.83	.04
8. Hygiene of Individual	.89	.10
9. Home Sanitation	.87	.09
10. Degree of Family Illness	.68	.06

TABLE 20

FACTOR ANALYSIS OF 13 DEF SCALES*

(N = 113)

DEF VARIABLE	FACTORS			
	I	II	III	IV
% VAR.	23.80	17.68	14.75	17.10
1. Numerical Intelligence	.95			
2. Verbal Intelligence	.93			
3. General Intelligence	.94			
4. Intellectual Functioning			.70	
5. Perception		.49	.45	
6. Dexterity			.62	
7. Aspiration			.79	
8. Projective				.87
9. Attitude Toward Family				.77
10. Attitude Toward Government				.74
11. Attitude Toward Training		.87		
12. Attitude Toward Child Education		.69		
13. Attitude toward Affection		.85		

* Loadings <.35 omitted

TABLE 21

FACTOR ANALYSIS OF MEDICAL RATINGS*

(N = 113)

MEDICAL DEF VARIABLE	FACTORS			
	I	II	III	IV
% VAR.	23.19	18.84	12.96	11.22
1. Oral Hygiene	.76			
2. Muscle		.69		
3. Bone		.66		
4. Respiratory			.91	
5. Cardio Vascular	.75			
6. GI & GU Systems				.87
7. Endocrine & Weight	.78			
8. Neurological		.72		
9. Sight	.60			
10. Hearing		.53	.58	

* Loadings < .35 omitted

TABLE 22

Test for Independent Contribution of Model 1 Predictors

Full Model R^2= .6609
df_1=1 df_2=53

Restricted Model R^2	F	P	Predictor
.5863	11.662	.0016	Sum of Codes for Health Care
.6243	5.728	.0192	Sum of Codes for Improved Financial Functioning
.5084	23.833	.0001	Sex: 1=Male; 0=Female
.6410	3.111	.0799	1 if White-Mexican Extraction (Latin American); 0 otherwise
.6251	5.598	.0205	1 if Felon; 0 otherwise
.6280	5.147	.0258	1 if Steady Work History up to Immediate Past; 0 otherwise
.6160	7.026	.0103	Age at Time of Referral
.6004	9.457	.0036	Respiratory
.5441	18.251	.0002	Intellectual Functioning
.6314	4.617	.0341	WAS Factor Scale I

TABLE 23

Test for Independent Contribution of Model 2 Predictors

Full Model R^2=.7178
df_1=1 df_2=53

Restricted Model R^2	F	P	Predictor
.6969	3.940	.0495	Number VR Interviews During Referral Status with Other Placement Resources
.6808	6.959	.0106	Sum of Codes for Educational or Vocational Training
.7044	2.525	.1141	Sum of Codes for Improved Family Functioning
.6291	16.670	.0003	Number of Interviews, Employer(s)
.5908	23.868	.0001	Training and Training Materials (cost)
.6476	13.188	.0009	1 if Steady Work History up to immediate Past; 0 otherwise
.6826	6.609	.0125	1 if Spotty Work Record; 0 otherwise
.6448	13.717	.0008	1 if Had Extensive Vocational Training; 0 otherwise
.6630	10.306	.0026	Age at Time of Referral
.7005	3.255	.0734	WAS Factor Scale II

TABLE 24

Test for Independent Contribution of Model 3 Predictors

Full Model R^2=.5235
df_1=1 df_2=58

Restricted Model R^2	F	P	Predictor
.4249	12.008	.0014	Sum of Codes for Health Care
.3480	21.365	.0001	Sex: 1=Male; 0=Female
.4366	10.576	.0023	Age at Time of Referral
.4725	6.205	.0149	Respiratory
.4037	14.584	.0006	Intellectual Functioning

TABLE 25

Test for Independent Contribution of Model 4 Predictors

Full Model $R^2=.5902$
$df_1=1$ $df_2=58$

Restricted Model R^2	F	P	Predictor
.4810	15.463	.0005	Number of Interviews, Employer(s)
.4542	19.259	.0002	Training and Training Materials (cost)
.3926	27.977	.0000	1 if Steady Work History up to Immediate Past; 0 otherwise
.4858	14.783	.0006	1 if Had Extensive Vocational Training; 0 otherwise
.5415	6.893	.0107	Age at Time of Referral

Table 26

Test for Independent Contribution of Model 5 Predictors

Full Model $R^2 = .5972$
$df_1 = 1$ $df^2 = 56$

Restricted Model R^2	F	P	Predictor
.3586	33.176	.0000	Sex: 1=Male 0=Female
.5494	6.647	.0121	1 if Felon; 0 otherwise
.5133	11.671	.0015	1 if Steady Work History; 0 otherwise
.5389	8.109	.0062	Years in school
.4636	18.575	.0002	Respiratory
.5195	10.805	.0021	Intellectual Functioning
.5463	7.078	.0099	Perception
.5694	3.862	.0514	WAS Factor Scale I

Table 27

Test for Independent Contribution of Model 6 Predictors

Full Model R^2=.4656
df_1=1 df_2=58

Restricted Model R^2	F	P	Predictor
.4167	6.243	.0147	1 if Steady Work History up to Immediate Past; 0 otherwise
.4187	6.023	.0163	1 if had Extensive Vocational training; 0 otherwise
.3488	13.598	.0008	Age at referral
.4222	5.639	.0198	Respiratory
.4290	4.906	.0289	Intellectual Functioning
.4452	3.155	.0774	Projective

Table 28

REFERRAL AND CASELOAD REPORT (R-100)

Closed Success Rehab.	Closed Unsuccessful in Plan	Closed Plan Not Implemented	Closed from Referral
68	14	15	84

288	total cases for dual services
181	closed for all reasons
107	at end left on two caseloads
46%	ofall closures were from referral
55%	accepted for full services
38%	of all closures successful.
70%	of accepted cases (for service) successful